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The transition to parenthood : a descriptive study of first-time mothers in nuclear and traditional families in Korea.

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THE TRANSITION TO PARENTHOOD: A DESCRIPTIVE STUDY OF FIRST-TIME MOTHERS IN NUCLEAR AND TRADITIONAL FAMILIES IN KOREA

A Dissertation Presented

by

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ABSTRACT

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Few studies have been conducted on the transition to parenthood in the context of Korean society, where rapid modernization has brought about abrupt changes in family structure for young couples. The purpose of the present study is to describe the experiences of 52 urban Korean primiparous mothers during their transition to parenthood, by comparing maternal adaptation in nuclear and traditional family settings.

All mothers were interviewed at the hospital after delivery and one week later, at each mother's home. The degree to which the pregnancies were planned, marital satisfaction, mothers' observation of traditional customs, such as Taegyo, levels of maternal depression and self esteem, and maternal adaptation were measured.

The data show that mothers who lived in traditional family settings received more support from their families and were more likely to use their mothers as sources of information on childcare, to observe the traditional customs related to childbirth, and to breast-feed, than the nuclear family mothers. Although living in nuclear family settings, the nuclear family mothers maintained close contact with their families of origin. Their husbands were more involved in childcare, and the mothers were more likely to use books and peers as sources of knowledge about childcare. They were more self-reliant and less depressed than the traditional family mothers.

The findings suggest that the transition to parenthood is influenced by mothers' lack of information about pregnancy and child care, by the lack of previous experience in childcare, and by the quality of the support mothers receive.

These results provide support for preventive educational programs, designed to provide information and modeling of childrearing practices for new mothers. These principles should be based on the integration of the findings of modern psychology and medicine and traditional beliefs and practices of related to parenthood.

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CHAPTER 1

INTRODUCTION

Focus of the Study

The family is the major context for child development in any society. Family systems do not exist and function within themselves. Rather they are embedded in other social systems and institutions. The values, beliefs, and practices of the social network, community, and culture all have a significant effect on the family and on the development of the child (Bronfenbrenner, 1979).

The cultural changes in a society therefore, bring changes in family life-style and family structure, which, in turn, have a significant impact on childbearing and parenting (Popenoe 1988; Lancaster, Altmann, Rossi, & Sherrot, 1987). The process of industrialization in predominantly agrarian societies in developing countries has brought various social changes including a number of fundamental changes in family structure.

The family in preindustrial society was a cohesive social unit that functioned as a unified labor force, invariably held together by a patriarchal figure. But industrialization has necessitated specialized division of labor, which, in turn, has necessitated division of family into specialized labor forces. Thus, a number of smaller, nuclear families dispersed to specialized work places in urban settings away from their family of origin. The

division and dispersion of the family caused by the process of industrialization ushered in changes in parents' concepts of the value of children (Aries, 1973) and also introduced changes in cultural traditions and practices related to childbearing and childrearing (Popenoe, 1988; Kay, 1982; Liljestrome, 1980).

The present study focuses on the experiences of a sample of first-time Korean mothers in a contemporary urban setting in Korea and examines the factors that influence the transition to parenthood by analyzing the planning and timing of parenthood and the nature of family and social support during the transition period. An examination is also made of the relationship between marital relationship and maternal self-esteem as well as mothers' emotional well being during the pre/postnatal period.

This is a short-term longitudinal descriptive study. Data were collected over the first month of life from the Korean first time mothers in an Urban center in Korea. Descriptive statistics, Chi-square test, t-test, and the Pearson Product-Moment Correlational method were used for addressing these problems.

Background

In most societies today, family life and childbearing traditions are changing rapidly in response to larger cultural forces in both the industrialized West and developing countries (Kay, 1982).

Since the 1960s Korea has emerged from a history of five thousand years as an agrarian economy to become a technologically industrialized nation. As one of the fastest developing countries in the world, Korea has been experiencing radical changes in family life and family structure over the last thirty years. This 30 year period is equivalent to the 200 years that Western societies required to undergo a similar fundamental transition, as they moved from being agrarian societies to becoming technological ones.

Korea is one of the most densely populated countries in the world, with 1,132 people per square km (Korean Census, 1988). Governmental policies on decreasing Korea's population have made contraception and abortion available to almost all Korean women, even in the rural areas. The birth rate rapidly declined in the 1970s, and it is predicted that it will be at a zero rate by 2004.

The most dramatic changes in Korean society began in the 1960s when industrialization and modernization policies were introduced into the country. The rapid enhancement of the standards of living, decrease in the infant mortality rate, and women's awakening sense of selfhood due to higher education all resulted in profound changes in the traditional parental value systems. Modern Korean women want fewer children, and young mothers prefer to experience childbearing only once or at most twice in their life-times.

Industrialization also brought about a great migration of the population, mostly from rural areas to urban centers. The Korean Census of 1990 reveals that more than 20% of the total population changed their residence from rural areas to urban centers. One quarter of this percentage consists of young people between the ages of 15 and 19. (Yu OY, 1978). They tend to leave the rural lands to their aged parents, while they move into big cities for job opportunities and tend to settle there permanently (1990 Census).

The increasingly predominant influence of Western culture in Korea since the end of World War II must be acknowledged as a major factor in the modernization process of the traditional society. Exposure to the values of individualism, egalitarianism, high technology, and modern higher education for women has strongly influenced Korean family life and childbearing beliefs and practices.

The process of modernization and westernization has had a direct, modifying impact on the traditional ethics and beliefs relating to childbearing and childrearing. The priority of filial loyalty as a social ethical code and the authority of the father figure, once the central tenets of Korean family life, as well as the educational role expectations of grandparents toward grandchildren, all have been weakened progressively and considerably.

Most importantly, the nuclear family has become the most common pattern of family structure in Korea, replacing

the traditional extended family (88% in 1990 Census). Breaking away from the extended and multigenerational family, today's young people are more likely to live as a couple, away from their family of origin. Thus, today's young couples in Korea may not have the chance to observe early parenting practices. Furthermore, in the event of stressful events occurring in the course of life, they may have difficulty in availing themselves of extended family support. This may be especially true during the transition to parenthood.

Statement of the Problem

The transition to parenthood has been considered as a crisis by some theorists and researchers (e.g. Hill, 1949; LeMaster, 1957; Shapiro, 1979), or as a normal stressful period (Hobbs & Cole, 1976) because of the abrupt changes in the mother's personal and occupational life. However, recent research suggests that the transition to parenthood may not only be a period of stress and crisis but may also have positive affects on the mother's psychological development (Russell, 1974). This is consistent with developmental theories such as Erikson's (1950), which conclude that crisis or stress can be a force for growth as well as dysfunction across the life-cycle.

Research suggests that in modern societies first time mothers have difficulties in the transition to parenthood period due to: (a) lack of preparedness or the absence of

any previous experience in childcare (DeVries, 1988; Rossi, 1968; Rappaport, Rappaport, & Streilitz, 1977), (b) absence of social support because of the isolation of the family from its origin (DeVries, 1988; Fischer, 1988; Daniels and Weingarten, 1982; Rossi, 1968), and (c) Discontinuity of cultural and traditional values of parenting due to the absence of the elder members with the knowledge and skills of parenting (Kay, 1982).

Goals of the Study

This study has two primary goals. The first goal is to describe the experiences of a sample of first-time mothers during the transition to parenthood and to compare the transition in mothers living in nuclear families with that of those living in more traditional extended family settings. The second goal of the study is to pose a set of questions, which will examine specific cultural and psychological factors that it is hypothesized, may influence the transition to parenthood.

The specific questions to be asked are:

1. How did first-time mothers in an urban setting in contemporary Korea feel about their pregnancies and about becoming mothers? Were there differences between the traditional and nuclear family groups in this regard?
2. How well did the first time Korean mothers plan for their pregnancies and prepare for the parenthood? Were there differences between nuclear and traditional family mothers

in the planning of pregnancy and preparedness for parenthood?

3. What was the major source of the knowledge of pregnancy and childcare among Korean first-time mothers? Was there a difference between nuclear and traditional mothers in terms of their sources of information about pregnancy and childcare?

4. What was the level of social support of first-time Korean mothers? Was there a difference between the nuclear and traditional family mothers?

5. How did first-time Korean mothers value the traditional beliefs and practices related to pregnancy, birth, and childcare? Was there a difference between nuclear and traditional family mothers in their level of belief and practice?

6. What was the level of depression among first time Korean mothers during pregnancy and in the postpartum period? Was there a difference in depression levels between mothers in nuclear and traditional family settings?

7. What was the level of self esteem in this sample of first-time Korean mothers? Was there a difference in the levels of self esteem among the nuclear and traditional family mothers?

8. How well did first-time Korean mothers adapt to motherhood and were there differences in the quality of

maternal adaptation between the nuclear and traditional family mothers?

9. What was the quality of the marital relationship of first-time Korean mothers? How did the quality of the marital relationship differ among nuclear and extended family mothers?

10. How did first time Korean mothers adapt to breast-feeding and rooming-in for their babies? Were there differences between the nuclear and traditional family mothers in breast-feeding behavior and room arrangements for infants?

11. What were the correlational relationships among demographic variables, maternal self esteem, maternal depression, maternal adaptation, planning of pregnancy, social support, and fetal education?

Rationale for the study

This study should contribute to a greater understanding of the transition to parenthood by describing this transition in a Korean setting. While there have been many studies of the transition to parenthood in the context of Western societies since LeMaster (1957), few have been done with reference to non-Western societies (Levine, 1980; LeMaster, 1957). The present study has the value of being the first study, to document the transition to parenthood in Korean society specifically. It will be the basis and starting point for future studies.

This study provides data on a Korean sample of full term normal infants and their mothers. The findings will provide the base line data on the transition to parenthood in an urban Korean sample, on first-time mothers and their infants and families. These data in turn should facilitate the development of an early intervention program for new mothers who may have difficulties and problems during pregnancy and childcare.

This study is designed to provide information and a possible guideline for Korean society and newly emerging developing countries. In the history of family development within the Western tradition (Aries, 1972; Popenoe, 1988), the nuclear family emerged as an "ideal" family life style in terms of quality development of family members, the intimate relationship between couple, and between parent and children, without the oppressive climate often found in traditional extended families. Some manifestations of current development in the post-nuclear family structure and life-style of western advanced societies, such as divorced families, single parent household, and cohabitation have less optimal outcomes and are often viewed as leading to family dissolution by some sociologists (Popnoe, 1989). Modern western societies are challenged by the demand of today's young parents to take over early socialization of their young (DeVries, 1988). Psychological vulnerability of the next generation of infants living in isolated nuclear

families or post-nuclear family structure is a matter of grave concern to both professionals and parents in an emerging industrial society such as Korea.

In the midst of the rapid change and in spite of the apparent attractiveness of the life-style of the nuclear family life-style, Korean society has maintained and emphasized the importance of traditional family life-support. In Korea, today's young people need to develop the possible strengths that nuclear family life-style has to offer without breaking the continuity of tradition found in extended traditional Korean family life.

CHAPTER 2

LITERATURE REVIEW

Theoretical Background

The literature on the transition to parenthood appears primarily in the fields of sociology, psychology, nursing, and medicine --- obstetrics, pediatrics and psychiatry. Transition to parenthood was viewed through various theoretical perspectives, such as psychoanalytic theory, developmental psychology, family systems theory, sociology, and sociocultural perspectives.

Within the psychoanalytic perspective, pregnancy is viewed as a period of crisis involving profound psychological as well as biological and physical changes, much like puberty or menopause (Bibring, 1959, 1961; Benedek. 1959). It is an important developmental stage that requires significant adjustments for the individual. The outcome is influenced by current reality factors and earlier unresolved conflicts before pregnancy, which can become predictable problems during the transition to parenthood (Benedek, 1959; Bibring, 1959, 1961; Cohen, 1979).

Many women experience fears, anxieties, and worries about themselves and the unborn child during pregnancy because of factors such as age, if they are over 30, or the effects of drug, alcohol consumption or smoking, the possibility of death or injury during pregnancy or

childbirth and the possibility of the baby being abnormal (Bibring, 1959, 1961; LaRossa, 1981). Mothers may suffer uncomfortable feelings about their physical changes and physical conditions such as constipation, tiredness, and vomiting. Many women also experience radical changes in mood during pregnancy and find their moods difficult to control (Bibring, 1959, 1961; LaRossa, 1981).

It was proposed that the woman's relationship with her own mother as role model contributes significantly to the woman's emotional state during pregnancy. Women's perceptions of their own mothers and their relationships with their own mothers were related to their reactions to fear of pregnancy (Caplan, 1967; Bibring et al., 1961; Benedek, 1970). Weigert et al (1968) reported that women who were unable to use their own mothers as models more frequently experienced emotionally difficult pregnancies.

The sociological perspective views the transition to parenthood in the framework of the family life-cycle. In family sociology individual development is embedded in family development and is influenced by the functioning of social roles (Hill, 1970, 1973; La Rossa & La Rossa, 1981; Belsky et al. 1983; Entwisle & Doering, 1978). During the transition to parenthood, especially during the postpartum period, new parents have to adjust to abrupt role changes as they move from the spousal role of the dyadic system to the parental role of the triadic system. This transition

requires more instrumental support because of the added frustration of caring for a demanding infant (Rossi, 1968). Sociologists point out that today's mothers have great difficulty in the transition because of inadequate preparedness for motherhood due to lack of models and because of the isolation of the mothers from their family of origin (Rossi, 1968).

The Family Systems Theory (Minuchin, 1974) approaches the transition to parenthood with the whole family as the basic unit of analysis. In contrast to developmental theories, which focus on the individual, family system theory focuses on the structure of relationships and interactions between family members. As extremely organized interfactional groups, families attempt to maintain homeostasis through unstated rules about roles and behaviors in the family. When these role boundaries are unclear, the family is in a dysfunctional state (Minuchin, 1974). Family systems theory suggests that we must examine the experience of the whole family in any examination of the transition to parenthood.

Developmental Psychology focuses on individual development during the transition to parenthood, from a life-span perspective. Viewing this period as part of normal developmental change, it argues that the context and timing of motherhood may affect maternal adaptation, i.e. the timing of parenthood, the marital relationship, the

historical moment, the individual characteristics of the mother-child relationship, and the social support of the family and of society all will influence the transition to parenthood (Mercer, 1986; Rossi, 1980; Grossman et al. 1980).

Developmental theory offers a view of the growing individual, and it demonstrates the need to look at the transition process over time, not as a discrete event but as a process. The developmental changes of any individual can bring change for the whole family. The family system may be influenced by developmental changes in its individuals. Ideological changes of a society can also influence changes in the family and vise-versa. No single source of change can account for the complexities of family development during the transition to parenthood (Shapiro, 1979).

The transition to parenthood has also been studied from a cultural perspective (LeVine, 1980; Nugent et al., 1987, 1991). Human parental care shares similarities across cultures as well as showing a wide range of variability. The similarities in human child- care are due to the innate sensitivity of all mothers to infant signals for nurturance and human infants' special ability to direct the goal for maintaining physical proximity to caregiver and for interacting with others (Bowlby, 1969; Bretherton, 1987). The differences are due to cultural variations. Parents raise a child in the beliefs and traditions of their

culture. Robert LeVine (1980) maintains that each culture, social class, or subculture has its own parenting formula and communication patterns, which have evolved over time as a unique adaptive response to that environment. Parenting is a process of communication by which the message melted in a culture melts into the actions of children of the society.

Empirical Studies of the Transition to Parenthood

Working from Hill's psychoanalytically-based conceptualization of first time parenthood as "crisis" (Hill, 1949), LeMaster (1957) initiated a study of first-time mothers in their transition to parenthood. She found that a majority of the 46 middle-class parents in her sample experienced a severe crisis during their transition to parenthood. These findings were replicated in a study of 32 couples by Dyer (1963). Reviewing twenty years' study on the subject Hobbs and colleagues (Hobbs & Cole, 1976) concluded that much lower levels of crisis were experienced by new parents than those reported by either LeMasters or Dyer.

More recent studies with larger sample sizes (Russell, 1974) found that families reported only slight to moderate degrees of crisis and that the changes could be more accurately described as a "normative transition" rather than a "crisis." The authors demonstrated that women report a greater degree of crisis or difficulty than men, although the parents in Russell's study also reported a number of gratifying aspects in the transition to parenthood.

Empirical data suggest that the transition to parenthood can therefore be considered to be a normal event. This coincides with Rappaport's view (1963), which suggested that the term "normal crisis" better describes the phenomenon, and with Rossi's view (1968), which insisted that the transition should be viewed as a transition rather than as a crisis.

In general the data show that women more than men experience a certain amount of upheaval during pregnancy, labor, birth, and during the perinatal adjustment to a new baby. This upheaval is best referred to as psychobiological stress, as a normative crisis, or as a developmental phase. Most investigators agree that most families of healthy, full-term normal infants adjust well, or at least adequately, to parenthood (LeMaster, 1957; Goldberg & Michaels, 1988). Some individuals experience growth during the process, whereas others undergo strain.

Motivation for Pregnancy and the Transition to Parenthood

The nature of the mothers' motivation for parenthood influences fertility behavior, the quality of parenting, and coping behavior during the transition to parenthood (Goldberg & Michaels, 1988). Mothers with a strong motivation for having a child had an easy transition to parenthood that had a domino effect --- good things in one phase tended to bring on even better things at later phases. Russell's study of 271 couples (1974) suggested that the

level of crisis during the transition to parenthood was related to unplanned pregnancy.

Highly educated professional mothers who get pregnant late in time out of a strong motivation for parenthood show better adjustment in the transition to parenthood (Blake, 1981). Blake concluded that having a positive motivation for pregnancy, planning the baby, and being married longer before childbearing resulted in better adjustment to the transition to parenthood (Blake, 1981). Low motivation for pregnancy and low level of psychological health, the latter especially among first-time mothers, has been shown to be correlated with postpartum depression and with a difficult transition to parenthood (Grossman et al., 1980; Russell, 1974).

Timing of Parenthood and the Transition to Parenthood

The motivation for pregnancy and the timing of parenthood are important determinants in the transition to parenthood. Because of the wide range in reproductive years from the early teens to the forties, the motivation and skills for parenthood may differ at the time of the first birth for the teenager and for the mature women in her thirties (Mercer, 1986; Rossi,1968). Furthermore, timing has completely different outcomes both for the individuals involved and for family development. The young mother in her twenties may be physically strong, but she may fall short on psychological and personal maturity. Early parenting may

also hinder her educational and professional development. Young parents without a job or financial security may face serious difficulties in their childrearing. In contrast, the first time mother in her late thirties may be better prepared for parenthood in terms of her personal and professional maturity, which are more likely to provide the smooth transition. But for a late-timing mother the birth may carry other problems, especially medical risks both in pregnancy and childbirth (Rossi, 1968).

Belsky (1981, 1984) concludes that the timing of parenthood is an important factor in the adaptation to parenthood. Others suggest that older parents who were married for a longer period of time before conception made a better adjustment to first time parenthood (Hobbs and Wimbish, 1977; Dyer, 1963).

Daniels and Weingarten (1982) found that early timing couples were less egalitarian in their childcare. They had assumed that women do most of the household work and that men are helpers or staff persons in household activities and childcare. On the other hand, in their study the late-timing parents were more egalitarian and had the potential for a smooth transition to parenthood (Daniels & Weingarten, 1982).

The Marital Relationship and the Transition to Parenthood

The marital relationship is considered a factor strongly influencing a smooth or difficult transition to

parenthood. Cowan and Cowan (1988) conducted a study based on the assumption that, since the 1960s, the romantic view of marriage has disappeared in North American society, and that babies were now more likely to be viewed as potential disruptors of marital intimacy, and that marital satisfaction would decline during parenting. However, they found from their longitudinal studies that most contemporary parents cope well with the challenge during the transition to parenthood. The phenomenon that some couples cope well with the stress while other couples do not led them to identify the marital relationship as the most important variable and as the most influential in the transition period (Cowan & Cowan, 1988; Russell, 1974; Shapiro, 1979; Sherefsky & Yarrow, 1973).

A strong correlation between pre- and postpartum marital satisfaction has also been reported in recent empirical studies. Parents with positive marital relationships before the pregnancy cope better with the negative changes and stress of pregnancy and birth. Those with marital difficulties tend to have more nausea, and more emotional troubles, depression, and anxiety during the pregnancy (Doering & Entwisle, 1975).

Belsky (1983) and Easterbrook (1984) also report a strong correlation between marital quality and parent-child interaction. Therefore the quality of the marital relationship before conception is the most stable variable

and an important factor for the smooth transition to parenthood.

Social Support and the Transition to Parenthood

The importance of social support for psychological adjustment and health has received much attention from researchers recently (e.g. Hirsch, 1980). A mothers' social network support can provide four types of support to meet the parent's psychological and practical needs during the course of the transition, i.e., emotional support, guidance and information, tangible aid, and coherent support among couples. The availability of social support plays an important role in the stability and security of the couple during the transition by providing help in various stressful situations, in response to the pregnant mother's fatigue, her husband's business, or baby care.

Having adequate social support can moderate depression (Billups, Croukite & Moos 1983;), can reduce stress (Cassel 1976; Cobb, 1976), can lessen the risk of birth complication (Nuckolls, Cassel & Kaplan, 1972), can make difficult life-transitions less stressful, (Hirsch, 1980) and can help in nursing, resulting in a better flow of milk (Jordan, 1980).

During the pregnancy, the new parents' social network can be actively engaged in providing information about the mother's and baby's health, and in recommending certain health practices to deal with any somatic or emotional symptoms of the new mother. The course and outcome of the

transition to parenthood is influenced by the social environment in which the couple is surrounded (Gottlieb & Pancer, 1988). A denser social network has been found to provide more emotional stability for the new parents during the transition than loose-knit social networks (Birkel & Reppucci, 1983).

It seems important to have harmonious relationships between the new mother and the social networks. In some cases a social network's support can be fallible, or intrusive as well as supportive. It can cause stress as well as help, depending on how the mother perceives the network. Older sisters-in-law or mothers-in-law may help in baby care while interfering in new mothers' marital lives or demanding to be treated as special guests in the household. Their lifestyle and manners can cause conflicts, especially between senior and younger generations. Cronenwett's study (1980) revealed that many pregnant women joined a Lamaze program mainly in order to meet other highly educated employed mothers who were not available in their own social network.

Tilden's (1983) and McKinlay's (1973) studies demonstrated that tangible support during pregnancy moderated the impact of life stress on complications in labor and on gestation and delivery. Emotional support proved to be significantly related to the women's emotional equilibrium during pregnancy.

Hopkins et al. (1984) showed that the mother's social network support plays a crucial role in the prevention of postpartum emotional disturbances. Postpartum depression is related not only to marital discord (Grossman, Eichler, & Winrickoff, 1980) but also to lack of social network support (Gordon & Gordon, 1959).

Studies on the Transition to Parenthood in Korean Settings

There are few empirical studies on the transition to parenthood in Korean society, although recently two studies published in Korea have examined early parent-child relations.

Lee SukHyun's study (1990), of 40 Korean first time mothers reported that one third of the mothers did not have difficulties in their transition period. Most of the mothers reported that they did not feel any change in their marital relationship during the transition. Working mothers in the sample had a less stressful transition than non working mothers. All twenty working mothers in the sample were well educated with secure jobs in the Seoul area and they had strong social support from the family of origin during the transition. Lee concluded that in addition to the strong social support the gratification mothers received from their infants compensated for the difficulties of the transition itself (Lee, 1990).

Won Jungsun (1989) in her study reported that a moderate degree of difficulty was demonstrated by the first

time parents in a sample of 157 Korean couples. Women showed a higher degree of stress than did men. Working mothers, breast-feeding mothers, mothers with good health or with strong social support, or mothers with good marital relationships had less stressful transition.

Family Life and Early Parenting in Traditional Korean Society

The term "traditional" refers to past or historic beliefs and practices that remain current and will likely be carried on into the future. Traditions are at the core of a culture and are not easily changed. In a narrower sense, the term is used to describe those beliefs and practices of the past that oppose modern ones. Korean scholars define a traditional society in Far Eastern societies as one that existed before 1945, the point at which modern education was established through the introduction of Western culture (Lee, 1980; Yu 1980).

The end of World War II is regarded as the beginning of Modern Korea, when the country emerged as an independent nation, liberated after thirty-eight years of Japanese rule. Since 1950 the educational system has changed radically, and schools, especially higher educational institutions, were opened for thousands of young Korean people. Women also were encouraged to enter the field of higher education. Before 1945, there were only 1086 female college students in Korea. Since liberation from Japan, higher educational institutions

for women, including the world's largest women's university with twenty-thousand female students, have been established. Women's higher education has contributed greatly to the modernization of family life.

As industrialization increased from the 1970s through the present, women have made important societal contributions to the labor force and to the family economy. In 1987, about two million women were in the labor force and 44.7% of married women had jobs. The number of working mothers is increasing dramatically (An, 1990). Today more women participate in various societal level jobs, reversing the historically important maxim of Confucian philosophy of "man honoring and looking down on the woman." These changes in turn have introduced rapid and dramatic changes into modern Korean family life, in stark contrast to the traditional patterns of Korean family life.

Family Life in Traditional Korean Society

The traditional Korean household usually consists of grandparents, parents, and the eldest son, his wife and children. When the eldest son marries, he and his wife stay with his parents and younger siblings. All daughters marry eventually, without inheritance, and their names are never recorded on the family's genealogical record. Rather, a wife's name is recorded on her husband's family tree book, as the daughter of such and such a family. After their marriages, the second and third sons stay with their parents

for a year to learn the family's ideals and traditions before setting up their own independent households. It is very important that the eldest son takes the responsibility for caring for his parents in their old age; he is also responsible for ancestor worship.

Koreans have a strong sense of pride in their five-thousand year history and in their ethnic unity as a people. Believing themselves to be descendants of one founding father, the Korean people have always tried to keep their blood pure by not intermarrying with other ethnic peoples. As an Asian feudalistic society, the nation itself could be considered a large, extended family. Filial loyalty and family loyalty were traditionally considered the highest values. They were extended to the father first, then the grandfather, then to the chief of the same family name, and finally to the person at the top of the societal structure, the king. Traditional Korean society was based on Confucian philosophy that was the founding ideal for the last kingdom (Yi Dynasty, 1392-1910). Confucianism, with its strong ethical principles, has helped bind the society together, because it stresses explicitly the importance of having a strong sense of order in human relationships between king and people, father and son, man and wife, old and young, and upper and lower classes. Each entity has different privileges or lack of privileges and benefits or disadvantages according to its position in the

relationships. Even different forms of language are used according to these relationships.

There were four distinct classes in traditional society: aristocrats, middlemen, commoners, and the despised class, all of which were inherited by birth. Classism was very strong in every aspect of life. For example the despised were talked down to with the form of language reserved for children in other classes. In the early 1950s, when Koreans had their first democratic election, a highly admired aristocrat running for congress in a southern rural area talked courteously to his region's residents, even to a butcher who belonged to the despised class. It was a radical change.

Confucianism values the family as the most important cell for societal life and for enculturation. In contrast to western society, in Korean culture the family, as a group, has priority over an individual. One always identifies oneself as a member of a family household by its name. The family name of origin guarantees one's identity, so that one bears the family name; whether an individual succeeds or fails, he or she does it as a member of the family.

The concept of family is related to the sense of an individual having eternal life, because each person is thought to have a connecting link to the past, to the present, and to the future in terms of his or her family history. Therefore a family includes not only those who are

alive in the present but also those who lived in the past and those who will live in the future. Thus, ancestor worship and the celebrations of pregnancy and birth are observed as the most cherished of all family events.

The extended family household members who bore the same name had a strong sense of belonging to the family clan. They labored together to grow rice, their only crop, which required an extensive labor force. Therefore the ability to produce children, especially male children, was very important. Only sons received the right of inheritance from parents, and it was the eldest son who inherited the house and half of the parents' assets. The other half was divided among the other sons. The father-son relationship was considered more important than the husband-wife relationship. Traditional Korean society can be said therefore to have been a father-son relationship and male-oriented society.

Because males had a higher status, there was strong preference for male children in Korea. Bearing a male child for a woman was considered an absolute obligation to the household into which she married. Foreign visitors to Korea in the 19th century wrote that "Koreans are male child maniacs. Male children are valued ten times higher than the female children for Koreans. But it is not that they despise the female children, and it is seldom one sees deserted children" (Son, 1978:72).

The father had absolute authority and power of decision-making with respect to family events, to managing the family economy, and to dealing with relationships outside the family. This power and authority was inherited by the eldest son. There was a strong sense of hierarchical order between generations and between siblings. Younger brothers were supposed to pay the same respect to their eldest brother as they did to their father.

The woman was supposed to be quiet and obedient to her husband, and the husband-wife relationship was secondary to the father-son relationship. Confucius stressed three obeying principles for a woman to follow: first, when she is young, she must obey her father; second, when she marries, she must obey her husband; third, when she enters old age, she must obey her son.

There were clear sex roles in the division of household labors. The woman was expected to do all tedious household chores, e.g., cooking and laundry, and care of children and the elderly. A man's involvement in household chores or baby care was considered shameful. There is a saying: "If a man enters into the kitchen, he lacks his facial hair."

The maternal side of family was subservient to the paternal side, which is revealed in the manner in which the relationship was described. One calls his/her father's brother "small father," but his/her mother's brother is called "outside uncle." There is an assumption that the

relationship with the father is more significant than that with the mother. Maternal grandparents are referred to as "outside grandparents," and grandchildren from daughters are referred to "outside grandchildren."

Since childbearing and childrearing were considered women's work in this patrilineal society, it was seen to be the wife's fault if no pregnancy occurred after marriage. A childless woman was considered, by tradition, to be a sinner who committed one of the seven evil conducts of women that could provide the husband with a reason for divorce.

When infertility became certain, husbands normally sought alternative ways to have children, either by remarrying, by obtaining concubines, by adopting a child, or by "receiving the seed." Since authenticity is valued in Confucianism, the sons of the second wife and concubines were not accepted into society with the full privileges of family members; and they likely met obstacles in their careers even if they were competent.

Adoption was never considered outside of a biological relationship and even then only on the father's side. If the eldest brother had no son, then a younger brother gave his eldest son to him for adoption. In order to have his own, blood-related child, the husband "received the seed," which was a traditional way of getting a surrogate mother. A healthy and prolific woman was selected and paid for bearing the man's child. From the moment of birth, the baby was

taken from the biological mother and given to the adopted mother.

Only married couples were allowed to bear a child. Premarital sexual intercourse or childbirth out of wedlock was considered an unthinkable shame. To prevent premarital sexual activities and incest, society enforced the strong supervision of children from the age of seven. Girls and boys were not allowed to sit or play together. Girls were made to stay in an inner section of the house with the mother and learn women's work, while boys stayed at the outer court with the father or grandfather and read books and did men's work.

Marriage

In traditional Korean society, the purpose of marriage was to ensure the succession of the family name. A marriage was arranged between two families by the parents without any concern for the young couple's feelings for each other. Marriage between different social classes was prohibited. Biological bloodlines were important for keeping the status of the household in society and to ensure the success of future generations.

Eugenic marriages were very much emphasized. In addition to the strong restriction on marriage between individuals with a different family status, it was illegal to marry a person with the same surname of origin.

It was also strongly advised for eugenic marriages that a young person marry someone who lived in another village at least 100 li (about 43 Km) away. A kinship-related village consisted of a network of extended family. Other families had difficulty in settling down in or even passing through the village. Villagers often showed their hostility to outsiders by collecting tolls from the passersby. Newcomers with a different family name who came from other regions were allowed to settle only if they stayed on the outskirts of the village. A common phrase referring to a village was "it is a such and such, two surname or three surname village." However, for the commoners, it was financially not affordable. Historical records show that families of higher status typically married into families in distant provinces (Lee, 1973).

Another serious concern in preparing for marriage was to avoid three surnames, i.e. the father's, the mother's, and the grandmother's. These restrictions were deemed wise precautions and legal prohibitions to prevent dysgenic diseases caused by consanguineous marriages. It has been known that certain societes or royal families, some physical impairment identified as resulting from dysgenic disease were caused by such marriages.

In addition to the legal traditions for selecting a daughter-in-law, it was also common to consider the various aspects of the girl's mother, e.g., her reproductive

history, especially the number of her healthy male children, as well as her virtues and behavior (Yu, 1980). There is a Korean saying which states: "you can tell the bride by her mother."

In traditional society, early marriages were customary. And brides usually were two to five years older than grooms. Brides in their upper teens married into the in-laws' household and lived there for several years, doing the household chores until the grooms grew into manhood. During this time, the young couple became acquainted with each other, helping make for a smooth transition to married life and providing a preparation period for parenthood before actual sexual intercourse.

Conception in Traditional Society

DongUiBoGam (Huh, 1974), the oriental medicine textbook of Korea, written by an inspired and passionate man of oriental medicine in the 17th century, defines manhood in terms of reproduction. "By the birth of his own son, he becomes a man" (DongUiBoGam v.2 n3 Huh 1974:50). In order to ensure healthy male children and to protect the future well-being of the family, various strategies were employed from early childhood to the marriage arrangement. Beginning in infancy, children were cared for differently according to their sex, and socialized in such a way that their procreation purpose. Boys were encouraged to keep their lower body part cool and uncovered and to show their

genitals with pride. Girls were advised to protect their genital areas and to always keep the areas covered and warm. Girls were admonished not to sit on cold or dirty floors.

Some secret exercises for young women to practice in order to facilitate conception included "breathing in" the moonlight while facing the moon. In the southern islands, women did moon-breathing exercise while walking on the beach; in other areas young wives practiced walking exercises on a bridge under a full moon (Yu, 1980). Moon and water represent the female in oriental philosophy, and it was believed that breathing in the moonlight would help the reproductive capabilities of women. In traditional Korean society women were supposed to stay at home and were not supposed to walk freely. All these walking and stepping practices can be seen as the type of exercises to strengthen the lower part of women's bodies and to enhance their reproductive capabilities.

There were also numerous scientifically rational and irrational customs, which were considered helpful in improving the chances of conception, e.g., avoiding chicken in the month of April; keeping away from weeping willows; and avoiding strong smells, rabbit meat, and mercury.

In traditional society, married couples were expected to have a child as soon as possible; and, even before marriage, they were advised to maintain a healthy state of mind and body in order to prepare for future parenthood.

DongUiBoGam (Huh, 1974) provided guidelines for the preparation and qualification of parenthood. For healthy conception, Huh wrote, it is a prerequisite for women to have menstruation regularly with an even amount, even color, and density. The male should have an adequate sperm count.

Women are admonished to be calm and virtuous in their emotions and actions. DongUiBoGam stressed that unmarried women are "imperfect" for parenthood. Women with too much desire, jealousy, bad behavior, who were extremely ugly or extremely beautiful were not fit for childbearing. Often extremely fat or extremely lean women were thought to be infertile (Huh, 1974 ed).

Young husbands were admonished the importance of maintaining their state of mind clear and noble at the time of conception and prude sexual activities for the child's future development. It was pointed out that fathers should recognized the awesome responsibility of creating a human being.

Lady Lee of Sajudang in New Fetal Education, written in 1780, wrote that

> ...the father's noble mind especially at the time of conception is as important as the mother's Taegyo of the ten months during pregnancy. .... A man and a woman were married to be husband and wife by arrangement. They must respect each other never losing proper etiquette and manners. Living together, the couple should be prudent in their speech and actions, and the man should never sleep except in his wife's bedroom, and he

> should refrain from sexual intercourse when he is sick or heavy-minded. He should keep himself away from hovering in a capricious or insidious mood. This is the way to become a father .... Therefore it is because of father's transgression that a child is dull with knots in spirit and vitality ..... A gentleman should "devote" his very best for the development of his own child (Lady Lee, Sajudang, 1974 ed.).

A Stoic sex-life -style was required for husbands even after conception and during the pregnancy. Men were urged to use a separate room in order to avoid miscarriages. Often, however men had extra-marital relationships.

Sex education for men in traditional society was very concrete. It taught very specifically about how, when, and how often sexual intercourse should occur for the preservation of male potency. It was recommended that, for a proper sexual life, a person in his 20s should have intercourse every four days; a person in his 30s once in every eight days; in his 40s once in every sixteen days; in his 50s once in twenty days; and for those over 60 very seldom (Suh, 1973). Other references show that, before the age of 20, one ejaculation is advised every other day, for those in their 20s every three days, for those in their 30s once every ten days, for those in their 40s once a month, for those in their 50s once every three months, and after the age of 60 once every seven months (Suh, 1973).

DongUiBoGam provided guidelines about the relation between the sex of the child and the time of conception. The first, third, or fifth day after menstruation is best for a male child and the second, fourth, or sixth day is best for a female child. At any other time except during these days, conception will not occur (Huh, 1974:54).

Taboo times for sexual intercourse were when there was no moon, when there was a full moon, at the ebbing tide, when there was a rain storm, during thick fog, during a severe cold or hot season, and when there were thunder, eclipses, or during earthquakes. Sexual intercourse was prohibited when one was drunk, too full or too hungry, sick, right after a bath when the skin and hair were still wet, or when one was too excited.

Taboo places for sexual activities were under the direct sun, under the moon or stars, beside fireplaces, inside a temple, in a kitchen, in a toilet, in a graveyard, or near a dead body.

Parents supervised the newlyweds as to the date on which they could sleep together in the same room by considering the wife's period and the young couple's health conditions. Lee Kyu Te (1979) describes sex education for young men in traditional society as being taken so seriously that it was included in the formal education of the village schools. At home, the grandmother assumed responsibility for teaching children the necessary knowledge about married life

before marriage, including the nature and frequency of sexual activities. Young men had to memorize all the rules and dates for sexual life and had to pass the grandmother's examination (Lee, 1979).

Young husbands were taught that if they had broken any of these taboos, the husband and wife would be ill-fated and their newborn baby would be mentally or physically defective, handicapped, or short lived. Consequently the family fortune would decline. It was believed that men's participation in preparing for pregnancy would be critical for their children's future development and the destiny of family fortunes. Through the father's participation in planned pregnancy and preparation for parenthood in traditional society, it was hoped to prevent miscarriages during early pregnancy, difficult deliveries or abnormalities of infant development, and other infections during pregnancy and the postpartum period. Some traditional beliefs and practices may not be scientifically reliable, but their involvement gave fathers opportunities to become more conscious of their parenthood and to take pride in the responsibility of becoming parents.

Recently the father's participation in early parenting due to a practical necessity have been increasingly recognized especially in Western advanced societies (Lamb, 1986). Practically speaking, without the man's cooperation in nuclear family settings, it is impossible for a woman to

get through the transition smoothly, especially during the postnatal period. However, in the traditional Korean society, men's involvement was not required for childcare but for measures that might prevent abnormal fetal development.

Taegyo

Traditional Korean society stressed the importance of human development in the prenatal period. The fetus was respected as a person, and ten months of life in the mother's womb was counted in a person's age. The infant, at birth, was considered already one year old. It was believed that the language, conduct, health, and emotional condition of the pregnant mother determine not only the physical, personal and mental development of the fetus, but also the sexual identity of the child after the birth. In traditional society, education began early during pregnancy. All the efforts that a mother made for the healthy development of the child in her womb were referred to as Taegyo. Pregnancy women were taught that ten months Taegyo has better impact on a child's development than ten years' teaching by an excellent teacher. Taegyo meant not only provisions for preventing miscarriages and difficult births but also a mode of developing a strong attachment between the parents and the child from pregnancy onwards.

Taegyo has been described in many educational, medical and religious books since the 18th century. Taegyo has been

cited widely in Korean literature and is better known in the rich oral traditions, which are well- practiced in Korea. The earliest literature on fetal education can be traced back to TeGyoSinKi, the New Version of Fetal Education, written by Lady Lee of Sajudang in the later 18th century. This book states that

> a man's temperament is inherent from birth, but character is nurtured. Building good character is the responsibility of the parents. Once parents realize this responsibility, how can they neglect children's education! The father gives me birth and the mother nurtures and teaches me to be a human being. As the most wonderful way of medicine is that of prevention, so the best way for teaching a child is through fetal education. Ten months of fetal education is more important than ten years' teaching by an excellent teacher" (Lady Lee SaJuDang; trans. Lee Sang In. 1937).

Lady Lee viewed fetal education as a form of early intervention. She believed that a child most likely resembles his/her mother because he/she grows in his mother's body for the first ten months. Because it is the mother's responsibility to raise an excellent child, she must endure any and all hardships for this purpose. The basic principle for fetal education was that the pregnant woman should try to be perfect and balanced in her posture, diet, emotions, language, and behavior.

There are some variations found in the content of fetal education according to locality; the following points are

the contents of fetal education common in both literary (Lee, 1979; Yu, 1980) and oral traditions.

1. A pregnant woman should sit down calmly, listening to good words and music, memorizing wisdom, reading poetry and doing calligraphy. She should not listen to bad words nor to gossip. She should not observe bad or unpleasant conduct, nor think evil about or inappropriate subject matter. This rule applied to every instrument she used: when she was sewing, for instance, she should not use a crooked needle.

2. After three months of pregnancy, nobility and refinement are to be formed. Pregnant women are advised to keep near and observe beautiful things, such as gems or flowers. They are recommended to look at nature and at the pictures of prestigious persons, men of history, men of wisdom, angels, gems, and beautiful costumes of the King's court.

3. A pregnant woman should not lie down on her side, neither leaning on the wall, or standing with unbalanced support on one foot. Lying down on her left side is permitted only during the last month for good luck.

4. There were strong taboos for pregnant women to prevent miscarriages and physical harms:

-Washing hair or washing feet near the delivery period.
-Carrying heavy things, too much hardship in household chores or physical fatigue due to too much workload.
-Climbing up on a high floor or a rock or climbing down into a deep place.
-Walking rough mountain roads and crossing dangerous streams.
-Going near fire or flood.

-Drinking alcohol, or drinking too hot or too cold drinks.
-Taking spicy or food that has an extraordinary flavor or essence such as ginseng, garlic, taro.
-Eating meat of weird looking animal.
-Using medicine abusively.

5. Pregnant woman should not indulge in:

-Excessive talking, laughing, crying, being afraid, or being shocked.

-Harming others physically or mentally, criticizing, mocking, stealing, upsetting, blaming, speaking in another's ear, or using excessive gestures.

6. Strong sexual constraints in pregnancy were advised. Sexual intercourse during the last month was believed to result in a sick child or a short-lived child.

7. She should avoid the following locations, which could cause miscarriage. (This should be understood in relation to living arrangements within households and the structure of traditional Korean houses.):

In the 1st month, the hallway floor (narrow and high)
2nd month, the window and door (small)
3rd month, the door threshold (high)
4th month, the kitchen stand of the hot pot (low)
5th month, the portable outdoor floor (no guard)
6th month, the storage (outside)
7th month, the step stones for the high floor
8th month, the toilet (outside, away from house)
9th month, the gateside room.(male servants'room)

A common type of traditional Korean house was a rectangular, I- or L-shaped, single story structure, built of wood, natural stones, and clay. The roof was not high and was thatched largely with straw for commoners or roofed with tile for upper-class people. The simplest form of the Korean house consisted of two rooms, one open hall between the two rooms, a semi-inside kitchen, with the toilet set apart and

away from the living quarters. Well-to- do families had larger houses, which would consist of the main family quarters at the center, a closet or a barn, and outside kitchen and toilet. At the front part of the inner yard were quarters for the master of the house and male guests, and a gateside room for servants.

Traditional Korean houses were built somewhat low, with relatively small rooms and few doors and windows. The door threshold was very high, and one would never step on it. In contrast to North American pioneers, Koreans never built their houses on the tops of hills, but rather at the feet of mountains, near water. This provided an easily attainable source of both household needs and rice production. However, the foundation of the house was often elevated in case of flooding and stepping stones were necessary to climb up to the floor of the house.

The rooms were heated via under-the-floor flues and referred as "ondol-bang", which are still so fashionable in Korea that modern high rise apartment buildings are facilitated with such ondol floors. Many Koreans still prefer to sit and sleep on cushions and thick mats on the ondol floor. The room used by the housewife was a place for family gatherings and the center of household management, and serving as a living, sleeping, and eating room. The front quarters were used as an personal office or a study, receiving guests or reading exclusively by the master of

the house. Normally, the master retired to the housewife's room for the night. Living in traditional house building pregnant women should pay attentions to building structure, arrangement, and locations of rooms.

8. Pregnant women was usually advised to take double portions of food. Generally meat was not recommended and rice and vegetable were advised. Fresh, well-riped, and well prepared food were advised to have. The carp was thought to be a good food for a baby's appearance. Some said that the baby would have large and beautiful eyes.

In sum, Taegyo evolved in such a way as to help both the father and the mother prepare for becoming parents. It was thought that mothers had the prime responsibility for childrearing and that nine months in the womb was the critical period for the development of the baby's character and temperament. A mother's fetal education was believed to have a direct affect on such development. Therefore, the mother was required to observe strictly the principles of Taegyo. The importance of emotional and nutritional provisions was very well recognized. The strong taboo on avoiding emotionally stressful situations was emphasized.

The paternal role in early fetal development was strongly emphasized. The underdevelopment of the motor tone and intelligence of the newborn baby was thought to be due to one to the father's transgressions. It was emphasized that paternal participation in fetal education prepared the

fetus to become a healthy, new-born baby. Paternal stoicism in sexual behavior was required during pregnancy. Without paternal understanding and involvement, fetal education on the maternal side could not be carried out successfully. Paternal involvement in Taegyo fetal education enabled fathers to become more conscious of their parenthood and to achieve better attachment between the father and the child, especially between the father and a son.

Traditional Korean society viewed the events of pregnancy and birth as the common work of the whole family. All family members of the household were to treat the pregnant woman with reverence, and they were to let her feel accepted as a respected member of the family. It was a common observation among women with childbearing experience that they had the most satisfying support from their mothers-in-law during their first pregnancy.

Dreams before and during Pregnancy

Dreams of pregnancy have a significant meaning in traditional Korean society. Usually the mother to be or elders of the household dream about pregnancy and the birth of a child. Stories were told that mothers of kings and great men had dreams before they gave birth. Such dreams contained images of an orchid, the sun, or the moon. Women dreamt about catching the sun or the moon with their skirts, catching a shooting star in their bosoms, picking fruits and nuts, or wearing precious gems and silk fabrics.

More importantly, it was the custom always to ask pregnant women what dream they may have had. They enjoyed interpreting the dreams, predicting the sex of the child as well as the fate of the child. Dreams of dragons, snakes, or bears, etc., were believed to represent a sign of a healthy boy, snakes are seen as a sign of cleverness, and fruit is a symbol of a girl child. In traditional society, a child born without such dreams was very rare. Dreams can be seen to serve as physical and psychological preparation for childbirth.

Preparation for Newborn Wear and for Mother's Diet

Approaching the expected date, the grandmother or the mother-to-be prepared clothes and a soft mattress and blankets for the newborn baby. According to custom, everything was made with white cotton, except the cover quilt blanket, which usually was made of soft, colored silk or cotton. Traditional newborn clothing often was made of an elderly person's clothes, to ensure the longevity of the newborn baby. Traditional babywear consisted of a loose top with wide armholes and long sleeves to prevent fingernail scratches on the child's face.

It was customary for the elder of the household to prepare special, good quality rice and unbroken dried seaweed for the expectant mother during the last month of pregnancy. Rice was considered so precious a crop for Koreans in traditional society that having rice was a

special treat for new mothers. The seaweed soup is rich in iodine and is believed to help stop bleeding, to help digestion, and to prevent constipation. Seaweed soup is also considered good for mother's milk and for a quick recovery after delivery. Seaweed soup is taken by mothers after delivery two to six times a day for at least three weeks, and it is included in the birthday menu.

Childbirth in Traditional Korean Society

In traditional society, it was said that "mother's death during childbirth is not unusual," and "if half is saved, it was a good harvest." As the date approached, mothers kept their personal belongings together in order to anticipate the possibility of death during childbirth. The mother was encouraged to do her daily routine as usual and to walk around the room as long as she was able. It was considered virtuous to face the fear of childbirth with calm and steadiness.

It was common to send the daughter-in-law to her own home to deliver the first child. A warm and attractive room was prepared for the birth and for the postpartum recovery. Typically, Korean rooms are surfaced with thick oil-soaked papers which is easy to clean. This is why the best room was selected for childbirth. The room was renovated with a new floor, wallpaper, and floor-heating system. After delivery the new mother stayed until the baby was 100 days old.

All births were home deliveries in traditional Korean society. As late as the 1970s, home delivery was very common in Korea. Usually the mother, mother-in-law, or an experienced woman helped with the birth. Professionally trained midwives appeared only in the 1930s and practiced actively up until the 1960s. When the birth pains began, the pregnant woman sent the message to her own mother first. Outside the birthroom, the women of the household prepared a table for the three gods of reproduction, praying for an easy delivery. The mother lay down to get through the pain; and, as the moment of delivery approached, she held the door-knob ring, someone else's hands, or the husband's hair topknot to give birth according to the local or household customs. (In traditional society men grew their hair and made this topknot after marriage.)

The support of the husband at the birth site also varied according to local or household customs. In some provinces, women gave birth without their husbands' support. In other provinces, the husband's involvement at delivery was encouraged---he held his wife's hands, shared her suffering, and helped her push. In upper-class households, the husbands refrained from business matters away from home during the last month of pregnancy. When birth signs appeared, the husband stayed in his room of the men's court, waiting for the news. The midwife, mother-in-law, or other

members of the family conveyed the husband's moral support to the delivering wife.

The northwestern mountain area had an amusing variation on a husband's support. Approaching the moment of delivery, the husband climbed up on the roof-top, holding on to the ridge of the roof, and concentrated all his energy on this, acting as the moral support for his wife in the room below.

Generally, most Korean women felt embarrassed to be seen at the birthing scene by their husbands or by other family members. They were encouraged to accept the event as part of the natural course of life and as their own destiny even though anticipating some risk. However they were never left alone and their own mothers or experienced women were always there during labor and childbirth. It was common that mothers comforted their birthing daughter like a baby, especially for the first birth, by massaging her abdomen and moisturizing her lips.

Usually they were waiting patiently for the time to come according to Nature's course and were careful to avoid having an episiotomy. However according to oriental fortune telling the time of birth determines one's life fortune. Delivery was sometimes forcibly postponed until the luck-bearing time of the day by blocking the birth passage in some way, such as by sitting the birthing mother on a saddle. Even in modern times, obstetricians are often asked to deliver the baby at a certain time with induction or

Caesarian section. One of the subjects in this study reported that she postponed pregnancy for one year to avoid the year of the horse. Girls born in the year of the horse were considered likely to have a difficult life.

When crowning took place, boiling water was provided for sterilizing the instruments used to cut the umbilical cord. Different instruments were used for cutting the cord according to the sex of the baby. In the case of a male infant, a sterilized knife or sickle was used; for a female infant, sterilized scissors were used. To promote the longevity of the baby, some fathers cut the cord with their teeth and swallowed their saliva. That this practice persists is suggested by the report that the father of the first prize winner of the 1992 Olympic Marathon, a Korean, reported that he cut his son's cord with his teeth at birth, in the hope that his son would be a healthy and strong boy.

According to custom, the umbilical cord was not be cut until the baby cried. After several cries, the cord was measured by the span of a hand and covered with blue silk or white cotton and then cut. Special attention was required to avoid touching the covering. The mother or the midwife massaged her abdomen in order to push out the placenta soon after the birth.

In some regions, the placenta was washed one hundred times in wine and kept in a white pottery vase with a used coin to be buried with the cut cord (Yu, 1980). In the

southern part of Korea the placenta was buried after the birth and the fallen cord was burned in the chimney or it was kept in silk for emergency medicine when the baby was sick.

After giving birth, the woman received congratulatory greetings from the close family members, including her husband and parents-in-law. The usual greetings, "Thank you for your effort" and "You did it well," mean more than "Congratulations." Women feel a sense of achievement, especially in the case of delivering a male child. There is the social recognition that it was the woman herself who was responsible for the birth.

The Care of the Newborn

First of all, the midwife or the assistant at the birth gave special attention to washing out the unclean substance of the womb from the baby's mouth, using soft fabric covered finger dipped in special herb tea. It was believed that the unclean substance would cause future illness. Then the baby was given a bath in warm water specially boiled with peach tree branch, silver, and a drop of wild sesame oil. The water had to be boiled and cooled to a comfortable temperature to exclude toxic elements. The peach tree was the symbol of reproductive capacity. The nipples of a female baby were squirted to let out milk; otherwise, it was believed that she would have problems with breast-feeding in her adult years due to caved-in nipples.

The newborn baby was then dressed, swaddled firmly with a comforter, and laid down next to his/her mother on a white small mattress. Physical proximity was an important the characteristic of Korean childcare. The father then came in to meet the child and to comfort his wife.

Caring for the Infant

In traditional Korean society, there was a unique set of specific childcare instructions on feeding, carrying the baby on the mother's back, laying the baby down, and taking the baby out. DongUiBoGam (Huh, 1974), Lady Lee, and other books and sources of the oral tradition agree on the following ten principles of childcare (Yu, 1980):

1. Keep the baby's back warm.
2. Keep the baby's abdomen warm.
3. Keep the baby's feet warm.
4. Keep the baby's head cool.
5. Keep the baby's chest cool.
6. Don't show him/her strange or monstrous things or scenes.
7. Keep his/her spleen and stomach warm always.
8. Don't feed him/her during or right after crying.
9. Don't feed him/her powder food.
10. Don't give him/her a bath too often.

More detailed instructions for infant care include:

-Lay him/her on the supine, with the head in the direction of the east or south, avoiding wind from the opposite direction of the door or window. And change the baby's head position frequently so as not to result in an unbalanced back of the baby's head.

-Swaddle the baby warmly, with the hands and arms tucked in to prevent startles during the first month after delivery.
-Lay a light weight cushion or a pillow slightly over him/her so that the baby can lean on it.
-While sleeping do not make sharp or abrupt noises.

-Keep the lower part of the male baby's body cool without covering; for a female child cover the bottom with cloth to protect it warm.

-Always massage the breast gently before feeding. Squeeze out some retained milk before feeding.
-Hold him comfortably at the left breast when feeding. Let the baby touch the mother's other breast with his hand while feeding.
-While feeding, caress the baby gently and quietly. Don't make him laugh while feeding.
-After feeding let him feel comfortable, but do not overstimulate.
-Mother should not take ginseng, malt, or spicy food during feeding months.

-When urinating, don't make him interrupt with touch or with noise. Don't play with or mock male organ of the baby.

-Do not ignore the baby's crying. Don't leave him alone while sleeping.
-Talk to the baby while he is awake.

-Do not press the top of the baby's head.
-Massage on baby's legs by stretching the legs occasionally when changing.
-Give the baby a bath everyday but not for long. For a balanced development, bathe the baby starting from his/her head one day and on the next day begin with his/her feet.

-Do not give big, luxurious parties in home of the baby or for sake of baby. Do not show off the baby. Do not praise the baby to others. Evil spirits are believed to be listening.

The Prohibition Rope

Kum-jul literally means prohibition rope. The practice of Kum-jul serves the purpose of announcing the happy events to the neighbors and passers-by and serves to keep away the visitors in order to protect the mother and newborn baby from various germs and diseases in the critical days after birth. Kum-jul was set across at the main gate of the house or the kitchen door at the level of a man's height and was kept there for at least three weeks.

The rope was specially made of thin rice straw by twisting it from the left side, which was thought to bring luck or to deceive the evil spirits. In the case of a male child, it was decorated with hot red peppers and charcoal alternately. The red pepper symbolized the male organ and strength, and charcoal stood for purification or cleansing. For a female child, it was decorated with charcoal and green pine boughs, which symbolized the woman's chastity and loyalty.

Kum-jul is still practiced in rural areas all over Korea, even though most of the babies are born in a hospital. With or without kum-jul, it is customary not to visit the newborn and his mother until at least three weeks after birth.

Naming the Newborn Baby

In traditional Korean society, the infant mortality rate was so high that new-born babies were not named immediately after birth. The infant was referred to by a temporary name, which was usually a very lowly name, such as "dog's dropping," so that no evil spirit would covet him. They were formally named after their third birthday.

Naming the baby is still taken very seriously in Korea. Many pay a specialist who studied oriental philosophy for name making, because they believe that one's name bears one's lot and destiny.

Postnatal Recovery Period

The mother was advised to keep herself warm enough to sweat during a month of confinement. Seaweed soup with white rice was the special menu served four to six times a day for four to six weeks. Even during the hot season, the mother kept herself warm on a heated floor for a quick recovery. She often was advised to wear socks so as not to get cold from the wind.

She abstained from all "cold," sour, hard, and spicy food, especially cold food. "Cold" refers to both the extrinsic and intrinsic nature of food in oriental medicine. Most of the raw vegetables and fruits like melons are categorized as cold food. Cold and sour foods were believed to damage the mother's teeth and give her gum problems for life, thus hindering recovery.

A new mother should postpone washing her hair for some days, and washing hands in cold water was not approved for one month. It was believed that, after delivery, a mother's joints were all loosened, and cold air would enter into the body any of its loosened joints, orifices, or through the soles of the feet. This was believed to cause life-long chronic aches and pains which could be cured only by proper care during the month of postpartum recovery of the next pregnancy.

New mothers were advised to lie down flat on their backs as often as possible in order to straighten out the

back bone that was curved during pregnancy. Kneeling, walking around, and bending their wrists were believed to cause sore knees, sore feets and wrists.

Sexual intercourse was also prohibited during this period. It was believed that sexual activities at this time would bring bad luck to the couple. The husband was thought to be particularly vulnerable to ailments such as poisonous lung disease.

These traditional practices continue in present-day Korea. Mothers are still told to observe a one-month recovery period properly and religiously, by lying down flat, having seaweed soup and rice, and keeping their bodies warm. Young mothers are supervised in these observances by their own mothers or mothers-in-law. Korean grandmothers are often shocked when they hear of Western women drinking cold water or juice and taking showers one day after giving birth. Korean grandmothers maintain that "they know nothing."

The Celebration of Sam Chil, at Three Weeks

SamChil means three weeks, which are considered the most important days for the survival of the infant. When the three weeks have passed smoothly, there is a day of celebration. Relatives and friends feel free to visit and to meet the newborn baby, and to bring gifts to the baby.

From this date, the mother reduces her diet of seaweed soup from six times to four times a day and tries to help in

light household work little by little. SamChil is a very important event in a Korean family, both for the survival of the newborn baby and for the adjustment of the new parents. In the case of her first childbirth, the mother usually stays at her parents' home during this period. Well-to-do parents keep her and the baby for up to one hundred days, at which time the mother and baby return to her husband's household. On the one-hundredth day, family members and friends are invited for a big celebration and banquet. People bring gifts to the baby, and the neighbors are treated to white rice cake.

A special table is prepared for the baby with food, rice cake, fruits, calligraphy brush or pen, money, thread, and books. The baby's future lot and profession are predicted by his first choice of one of these objects. This is the day that the baby first tastes his seaweed soup and rice, after the initial tasting of those on his/her SamChil, the twenty-first day of his life.

Feeding the Infants

Since mother's milk was the only source of nutrition for the baby's survival in traditional society, feeding the baby was a serious matter in the household. Stories are told to the effect that, in upper-class families in the old days, the mother-in-law supervised the feeding of the baby, hitting her daughter-in-law with a long bamboo cigarette holder if she was careless (Yu, 1980).

Until the secretion of milk, the baby was given barley tea. The first milk was usually thrown away, and the milk expressed after a long night or a long interval was also thrown away. It was advised that the breast should be massaged gently every time before feeding. Warm water or a warm wet cloth should be used in case of cleaning. The young mother should not be in a hurry before feeding and she should do it calmly and happily. She was not supposed to feed when she was cold, hot, angry, or in a bad mood. She should not take any drug, drink alcohols or smoke during this time.

There was no concern about schedules, as long as the mother was aware of the feeding. The baby had access to the mother's breast as long and as often as he wanted. Mothers were advised to hold the baby on their left sides, because it was believed that left side breasts were fuller than right side ones. Feeding was seen as a time of attachment between the mother and baby. During feeding, the mother concentrated on the baby, gently touching him and letting the baby touch her other breast. In traditional society, a child raised with breast feeding had his oral needs satisfied completely. Weaning was postponed until the next child was born. By then the child moved to his grandmother's breast. It had no milk but it still provided skin-to-skin contact and physical proximity and enhanced the child's sense of security (Yu, 1980).

One of the goals of this study, therefore, is to examine the degree to which modern Korean mothers are guided by traditional beliefs and customs and to describe how these values are integrated into the transition to parenthood in contemporary Korea.

CHAPTER 3

METHODS AND PROCEDURES

The Sample

The subjects for this study were first-time mothers recruited at hospitals and private clinics in the city of Daegu, Korea, immediately after delivery. They were recruited through obstetric doctors and nurses from the maternity department of the hospitals. The criteria for participating in this study were as follows: All mothers must be married and primiparous; all must have full-term normal healthy neonates; all must live in an urban setting in Korea.

The total sample included fifty two first-time mothers and their infants. Fifty percent of the mothers and their husbands lived in the same area with their family of origin and the other 50% of the mothers lived away from their family of origin.

The sample was sub-divided into two subgroups according to their living arrangements during the transition to parenthood period defined in this study as the period from the birth of the child to the end of the first month of the child's life: Those who keep their own residence as their place of confinement after delivery referred to hereafter as the nuclear family group, and those who went to their own parents or their in-laws' place for their recovery period

hereafter referred to as the traditional family group. The number of subjects in the nuclear group was 24 (N=24) and the number of subjects in the traditional group was 28 (N=28).

The age range of the mothers was 20 to 34 with the mean age being 26.8. Seventy percent of the mothers had their first child between the ages of 24 and 28, around the first anniversary of the wedding. The age range of their husbands was 25 to 37 years, with the mean age of 29.8.

The education level of the sample was high: 53.9% of mothers were college graduates and 40% were high school graduates and 7.7% finished middle school. The husbands' education level was higher than that of their wives': all of the husbands had at least high school education, three were in advanced studies, 63.5% were college graduates, and 30.8% were high school graduates.

The sample included 14 working mothers (26.9%), including 1 medical doctor, 1 pharmacist, 3 nurses, 3 secondary school teachers, 1 sales person, 2 owners of after-school tutoring services, 3 hand-craft workers. Their husbands' occupation included: 1 doctor, 7 students, 13 small-business owners, 30 white-collar workers, and 1 temporarily unemployed.

The average monthly income for the total sample was about $1,000 per month. Most of the families lived in rented one room apartments. This was their first residence

after marriage, except for those who were students or who were the eldest sons of the household, living at their parents' houses. In terms of their socioeconomic status, the sample can be classified as middle class.

All of the infants were born by normal vaginal delivery with Apgar score of 8 or above at one minute and at five minutes after delivery. All deliveries took place in a hospital or private clinics. Infants delivered at hospital were placed in Western style separate nurseries after delivery. Mothers were permitted to visit the nursery for breast feeding, if they wanted. Most cases the initial feeding was by bottle-feeding. Those infants delivered in private clinics were placed in the same room with mothers in Korean style ondol rooms.

The Research Setting

The city of Daegu, the third largest one in Korea with a population of 2.3 million inhabitants, has been a traditional center of education and culture in Korea. The city first mentioned in the 8th century documents, has been a historical center of Confucian scholarship, as well as a focal point of Buddhist culture. The city currently has 5 large universities, 3 university medical centers, many small colleges, community colleges, hospitals and clinics. Being the stronghold of the Presbyterian Church, the city also is an archdiocesan seat. Its leading industries are textiles and electronics.

Daegu is surrounded by mountains and the geological peculiarities of the piedmont region have made the city more isolated than other cities and regions. This isolation has made the inhabitants of the city socially more reserved and intellectually more conservative than their compatriot city-dwellers elsewhere.

The historical complexion of the city has changed drastically by the Korean Conflict (1950-53), during and after which time the long cherished sense of patrician isolation was rudely and forever disturbed by the necessity of domestic and international coexistence and cooperation. The new mandate for modernization and industrialization unleashed vast population movements from neighboring rural areas into the city, until the city had reached its present population level.

Although large metropolitan cities like Seoul, Pusan and Daegu, drained the neighboring and distant rural regions of their population and contributed toward the dispersion of the traditional, multi-generational extended family, Korea on the whole is small enough for the dispersed members of the extended family to maintain close ties to the original extended family, which is usually held together by the patriarch of the family. Thus, the incipient young city dwellers usually have family help and support available in the rural areas.

The sample in the present study is not representative of the total Korean population, but may be representative of middle class families in the city of Daegu. The data used here were collected from a large government hospital, the Red Cross Hospital, and a small private obstetric clinic, both of which are in Daegu. The data were collected between October, 1991 and January, 1992. Table 1. provides a description of the sample.

Table 1. Sample Characteristics

Variable	Total	Nucl.	Trad.
	N=52	N=24	N=28
Mothers' age			
Mean	26.8	27.3	26.3
Range	20-34	20-33	20-34
Husbands'age			
Mean	29.8	30.1	29.8
Range	25-35	26-37	25-35
Mothers' education			
Mean	H Sch.	Jr coll.	H Sch.
Husbands'education			
Mean	Coll.	Coll.	Coll.
Monthly Income			
Mean	$700-1000	$1000-1300	$700-1000
Range	$700-2000	$700-3000	$700-1500
Infants			
Male	25	8	7
Female	27	16	11
Weight	3287g	3292g	3282g
Range	2530-4400g	2700-4000g	2530-4400g

Procedures

Postnatal Hospital Visit Interview

The initial contact with the mothers began at the hospital immediately after delivery. With the permission of

the obstetric doctors and with the help of the nurses in the maternity section, the researcher was able to recruit eligible subjects.

While the new mothers were at the hospital, the researcher explained the purpose and the procedures of the research, including the right of the mothers to discontinue participating in the research at any time and the guaranteed confidentiality of information. If the mother agreed to participate in the study, she was asked to fill out a personal demographic information questionnaire. The researcher then interviewed her with a series of open ended questions about her prenatal and postnatal experiences. The interview also included questions about her marital relationship; her feelings of pregnancy; information about the kind of social support she had; her prenatal care; her level of depression during pregnancy; practice of Taegyo; of her feelings about labor and childbirth; and her feelings about becoming a mother. All the responses were recorded, and the interview took about one hour.

Home Visit at One Week after Delivery

At one week after delivery, the researcher visited the mother at her recovery place for a further interview. This interview included questions about the mothers postnatal experiences with the baby, especially questions about feeding and about caregiving. The researcher was accompanied by a visiting nurse.

At the time of the home visit, two sets of questionnaire forms were left for mothers to mail back to the researcher after being completed: The Postnatal Research Inventory (Shaefer and Manheimer, 1960) and Maternal Self Report Inventory (Shea and Tronick, 1988). Table 2 provides a description of the schedule and the assessments.

Table 2. Schedules of Data Collection

Time & Place	Assessment
Within 24 hours after delivery at Hospital	Interview CES-D (Radloff, 1977)
One week postpartum at the mother's home	Interview
One-two weeks postpartum at the mother's home	Questionnaires Postnatal Research Inventory (Shaefer & Manheimer, 1960) Maternal Self Report Inventory (Shea & Tronick, 1988)

Research Questions

1. How did first-time mothers in an urban setting in contemporary Korea feel about their pregnancies and about becoming mothers? Were there differences between the traditional and nuclear family groups in this regard?
2. How well did first time Korean mothers plan for their pregnancies and prepare for the parenthood? Were there differences between nuclear and traditional family mothers in the planning of pregnancy and preparedness for the parenthood?

3. What was the major source of the knowledge of pregnancy and childcare among Korean first-time mothers? Was there a difference between nuclear and traditional mothers in terms of their sources of information about pregnancy and childcare?

4. What was the level of social support of first-time Korean mothers? Was there a difference between the nuclear and traditional family mothers in this regard?

5. How did first-time Korean mothers value the traditional beliefs and practices related to pregnancy, birth, and childcare? Was there a difference between nuclear and traditional family mothers in their level of belief and practice?

6. What was the level of depression among first-time Korean mothers during pregnancy and in the postpartum period? Was there a difference in depression levels between mothers in nuclear and traditional family settings?

7. What was the level of self-esteem in this sample of first-time Korean mothers? Was there a difference in the levels of self-esteem among the nuclear and traditional family mothers?

8. How well did first-time Korean mothers adapt to motherhood and were there differences in the quality of maternal adaptation between the nuclear and traditional family mothers?

9. What was the quality of the marital relationship of first time Korean mothers? How did the quality of the marital relationship differ among nuclear and extended family mothers?

10. How did first-time Korean mothers adapt to breast-feeding and rooming-in for their babies? Were there differences between the nuclear and traditional family mothers in breast-feeding behavior and room arrangements for infants?

11. What were the relationships between demographic variables, maternal self-esteem, maternal depression, maternal adaptation, planning of pregnancy, social support, and fetal education?

Definition of Terms

Planned Pregnancy was defined as the intention of having a child and was measured by the following interview questions: Before you got pregnant, how much had you planned to get pregnant? The response was rated on a 5 point scale: 1. had not planned at all, 2. had not planned very much, 3. somewhat planned, 4. had planned a lot, 5. had planned very much.

Mother's Educational Level was measured in terms of the amount of schooling the woman had completed, such as middle school, high school, jr. college, or college graduate.

The Quality of the Marital Relationship was defined in terms of the mother's feelings of satisfaction in her

marriage and was measured by the following interview question: How satisfactory do you consider your married life to be? The answer was coded on a Likert rating scale from 1 to 5: 1. very unhappy, 2. unhappy, 3. neutral, 4. happy, 5. very happy.

Social Support was defined as both the formal and informal support the mother got during pregnancy, childbirth, and perinatal period. It included the network, nature and density and social support. Mothers were asked who had helped them during pregnancy.

The response options included:

1.husband, 2. parents/ in-law, 3. sister,
4. friends, 5. neighbors, 6. doctors.

Mothers were then asked: How did the person help you?

The responses included:

1. combination of all, 2. information on pregnancy,
3. encouragement, 4. instrumental works.

Then the mothers were asked: How often did he/she help you?

The response was rated 1 to 5 scale:

1. every day, 2. 1-2/wk, 3. 1-2/month,
4. at times, 5. rarely

The level of Social Support was measured on a 0-4 scale:

0. None at all, 1. one or two persons with occasional help,
2. one or two person with help on a 1-2 month basis,
3. one-two persons on a weekly basis,
4. one-two persons help every day.

Prenatal Care was measured in terms of the mothers' medical history during pregnancy. Mothers were asked the following questions: When did you first see the doctor? How many visits did you have?

Maternal Depression was referred to here as the depression the mother may have had during pregnancy and was measured by the CES-D (Center for Epidemiological Studies Depression Scale, Radloff, 1977) in the Prenatal Interview. Postnatal depression was defined as depression the mother may have had after delivery and was measured by 4 items in the Postnatal Research Inventory (Shaefer and Manheimer, 1960).

Maternal Adaptation was defined in terms of the mother's relationship with her newborn, her responsiveness to the child's needs, and her happiness in caring for the child. This was measured by the questionnaire adapted from the postnatal Research Inventory (Shaefer & Manheimer, 1960).

Maternal Self-Esteem was defined as the mother's confidence in her ability to care for her newborn and was measured by the MSI scale (Maternal Self-Report Inventory) developed by Shea and Tronick (1988).

Descriptions of Instruments

The instruments used for this study include:

1) HOSPITAL POSTNATAL INTERVIEW QUESTIONNAIRE (APPENDIX A),

2) CES-D Scale (Radloff, 1977, See APPENDIX A),

3) Home Postnatal interview (APPENDIX B),

4) Postnatal Research Inventory (Shaefer & Manheimer, 1960, APPENDIX C), and

5) Maternal Self-Report Inventory (Shea & Tronik, 1989, APPENDIX D),

1. HOSPITAL POSTNATAL INTERVIEW QUESTIONNAIRE

Mothers were interviewed individually during the mother's stay at the hospital after delivery. The interview usually took about an hour. The interview questions were based on Nugent's Irish study (Nugent, 1989). It is semi-structured and consisted of both open ended and quantifiable questions about the mothers psychological state and the marital aspects of her life, in her transition to parenthood.

The interview questionnaire included questions on: a) demographic information, b) mothers' prenatal and postnatal feelings about motherhood, c) mothers' prenatal health care, d) mothers' social support during pregnancy, labor and delivery, e)mothers' attitudes about "fetal education" and mothers' evaluation and observation of traditional customs related to childbearing, f) mothers' knowledge of milestones of child's development, and g) mother's feelings about labor, and about the childbirth experience. (See APPENDIX A)

2. THE CENTER FOR EPIDEMIOLOGICAL SCALES DEPRESSION SCALE, CES-D (Radloff, 1977) was filled out by each mother as a

measure of her degree of depression during pregnancy. The scale is widely used in epidemiologic studies as a screening tool and has been validated against standardized psychiatric interviews (Myers & Weissman, 1980). The CES-D scale is included in APPENDIX A (Question D1- D20).

3. HOME POSTNATAL INTERVIEW QUESTIONNAIRE

Each mother was interviewed about her experiences during her postnatal life with her baby at home, at one week after delivery. The interview lasted more than half an hour. The interview questionnaire included an assessment of:
a) the mother's feelings about her life with the baby,
b) the mother's observation of traditional postnatal customs, and c) her husband's involvement in childcare. (APPENDIX B)

4. THE MATERNAL SELF-REPORT INVENTORY (Shea & Tronick, 1989)

The MSI was administered to mothers between one to three weeks after delivery. The questionnaire was developed to measure the mother's adaptation to motherhood in relation to her feelings of maternal self-esteem in the postpartum period. For this study the shorter form was used. It consists of 26 items on Likert scales with scores from 1 to 5, from "completely false" to "completely true," and can be reduced to five subscales: a) caretaking ability, b) general ability and preparedness of the mother, c) acceptance of the baby, d) expected relationship with the baby, e) feeling about pregnancy, labor, and delivery.

This instrument has high reliability, face validity, concurrent validity, and construct validity and substantial external validity with other independent measures. For test-Retest reliability a Pearson Product Moment Reliability coefficient of $r = .85$, $p < .0001$ was reported at one week and one month. MSI has concurrent validity with the Epstein and O'Brien Self Report Inventory (1976) with a significant correlation coefficient of $r = -.74$, $p < .001$. For data analysis, the mean of the mothers' total raw scores was used.

5. POSTPARTUM RESEARCH INVENTORY (Shaefer & Manheimer, 1960)

This questionnaire was checked by each mother at home between one to three weeks after delivery. The postpartum inventory is composed of 40 items rated on a one to four point scale, from "disagree" to "mildly disagree," to "mildly agree," and to "agree". It can be reduced to 10 subscales: maternal happiness, need for assistance, irritability, positive perception of others, negative aspect of childcare, maternal acceptance, ignoring baby, need for sharing experiences, responsiveness to baby's needs, and postpartum depression. The total raw score is calculated and the high score means a higher or more optimal level of maternal adaptation.

Limitations of the Study

There were two major concerns in collecting the data for this study: the first was the nature of the study, which

required the respondents' deep emotional involvement in relating details of their personal lives. Because of the reserved nature of the Korean people, mothers found it difficult to open their minds to a stranger, even though the researcher was Korean and lived in the same city. People, especially young mothers do not want to be exposed to strangers, neither do they want their identity to be revealed through telephone contact. Young nuclear family mothers live alone during the day time, and they do not want to open their home to strangers, and some were also afraid that if they opened their doors they would be asked to buy some unwanted baby products.

Secondly, the study involved the newborn infant, and mothers were reluctant to have visitors during the postnatal recovery period, which in Korea usually lasts three weeks. It was interesting that the researcher was often welcomed by the mother's own mother during the home visit. However, mothers-in-law were more defensive and looked askance at the researcher. This was especially true in the case of baby boys.

Non-probability convenient sampling was used in this study so that the sample is not representative of the total Korean population.

Since this is the traditional resting period for new mothers in Korea and a very critical period for newborn babies, the researcher was very careful to ask permission to

visit the homes. In return mothers were offered counseling on baby care, were given demonstrations of feeding and bathing, burping, and on taking care of the cord.

The primary methodology used to obtain germane information was through the use of a semi-structured in-depth interview conducted with the mothers and through additional standardized assessment tools. The interview is a unique method that enables the researcher to collect data through face-to-face verbal interaction. It has both advantages and disadvantages. The interview method can provide a true picture of opinions and feelings, which a mailed questionnaire or paper and pencil questionnaire cannot capture (Borg & Gall, 1983). It obtains a higher response rate than mail surveys, and enables the researcher to explain and probe into the responses.

Some disadvantages include: the subject's reluctance to reveal certain private aspects of the self. The establishment of rapport between researcher and subject is necessary prior to the interview (Borg and Gall, 1983). In this study, the researcher made every effort to develop a comfortable relationship with each subject. One of the hospital nursery nurses who discharged the baby from the hospital accompanied the researcher. Another weakness of the interview method lies in the subjectivity of the researcher in the interpretation of the interview material (Borg & Gall, 1983).

The major contextual problem in conducting the interviews in this study was that often there were mothers or mothers-in-law at the scene so that the new mother sometimes could not express her feelings openly. Second, especially during the postnatal home interview, mothers felt too busy to take the time for the interview. Questionnaires were therefore very effective in getting additional data for this period.

In sum, the interview method has both advantages and disadvantages for this kind of study, which was a descriptive study designed to investigate the relationship between selected variables and the more objective data obtained from standardized scales.

Since the interview method is a highly subjective technique and the scales used in this study are originally designed for American populations, two pilot interviews were conducted to identify and eliminate possible biases and flaws in the design before the study began. All the questionnaire and interview material were translated into Korean. The pilot study was conducted with first-time Korean mothers in Amherst, MA. This enabled the researcher to check the clarity of the interview, and to get ideas of how best to record the interview data. The interview format was changed accordingly so that it could be understood more easily by the Korean subjects.

Data Analysis

In order to achieve the goals of the study, descriptive statistics, correlational analysis, and analysis of variance were used for data analysis. Descriptive statistics were used to describe maternal experiences over time for the total sample. Chi-square analysis and t-tests were used to compare maternal adaptations between the two groups--- between the nuclear and traditional family groups. Correlational analysis was used to examine the relationships between selected variables.

The results of these analyses are presented in the following chapter.

CHAPTER 4

RESULTS AND EXPLANATIONS

Descriptive Results

Mothers' Experience of Pregnancy and Motherhood

How did the first time mothers at an urban center in contemporary Korean society feel about their pregnancy and about becoming mothers? Were there differences between the traditional and nuclear family groups in this regard?

Table 3 reveals that Korean mothers' feelings about pregnancy and also about becoming mothers were very positive after delivery but at the same time they experienced feelings of stress in anticipation of childcare experiences.

A great majority of the mothers (84.6%) reported that they had happy feelings about their pregnancy, and 15.4% of mothers expressed mixed feelings about pregnancy, while none expressed unhappy feelings. As for the postpartum period 84.6% of mothers reported being happy about becoming a mother, 9.6% had mixed feelings, while 5.7% reported having unhappy feelings. All mothers who reported being unhappy belonged to the traditional mothers group. Table 3 also reveals that 55.8% of all mothers expressed moderate levels of stress in response to childcare, 26.9% of mothers experienced high levels of stress about childcare, while only 15% reported a smooth transition to parenthood.

Table 4 shows that there were no significant differences between the nuclear and traditional group in

their experience of pregnancy. Similiarly in Table 5 we see that there were no significant differences between the two groups in the postnatal period in terms of their attitudes towards motherhood. Table 6 shows that there were no differences between the nuclear and traditional group mothers in their experience of stress due to the demands of childcare after delivery.

Table 3. Mothers' Experience of Pregnancy, Motherhood, and Childcare.

			% of mothers and ratings		
Variable	Rating		Total	Nucl.	Trad.
			N=52	N-24	N=28
Feelings	Very unhappy	1	0.0	0.0	0.0
about	Unhappy	2	0.0	0.0	0.0
Pregnancy	Half & half	3	15.4	5.8	9.6
	Happy	4	30.8	17.3	13.4
	Very happy	5	53.8	23.1	30.8
Feelings	Very unhappy	1	1.9	0.0	1.9
about	Unhappy	2	3.8	0.0	3.8
Being a	So so	3	9.6	0.0	9.6
Mother	Happy	4	23.1	15.4	7.7
	Very happy	5	61.5	30.8	30.8
Feelings	Not at all	1-4	1.9	1.9	0.0
Due to the	Mildly low	5-8	15.4	7.7	7.7
Demands of	Mildly high	9-12	55.8	25.0	30.8
Childcare	Very high	13-16	26.9	13.5	13.5

Table 4. Comparison between the Nuclear and Traditional Family Mothers on Their Experience of Pregnancy.

Group	N	mean	sd	range	t-test	p
Total	52	4.38	.75	3-5		
Nucl.	24	4.37	.71	3-5	-.09	.93
Trad.	28	4.39	.78	3-5		

Table 5. Comparison between the Nuclear and Traditional Family Mothers on Their Experience of Motherhood.

Group	N	mean	sd	range	t-value	p
Total	52	4.37	1.03	0-5		
Nucl.	24	4.33	1.16	4-5	.20	.84
Trad.	28	4.39	.91	0		

Table 6. Comparison between the Nuclear and Traditional Group on Their Experience of Childcare Demands.

Group	N	mean	sd	range	t-value	p
Total	52	10.50	2.55	4-16		
Nucl.	24	10.20	2.55	4-14	-.76	.45
Trad.	28	10.75	2.56	7-16		

Planned Parenthood

How well did the first time Korean mothers plan for their pregnancies and preparare for parenthood? Were there difference between nuclear and traditional family mothers in the planning of pregnancy and preparing for parenthood?

Table 7 reveals that 32 mothers (62%) consciously planned their preganancy. Only 9 mothers (17.3%) reported they had unplanned pregnancies. By t-test there were no significant differences between the two groups on the degree to which they planned their pregnancies. According to Table 7, 17 mothers (32.7%) had prenatal care visit to the doctors by 4 weeks, and by 8 weeks of pregnancy 43 mothers (82.7%) had seen the doctors for prenatal care and 46 mothers (88.5%) reported that they practiced the Korean traditional fetal education for pregnancy. The great majority of mothers prepared well for parenthood and Chi-

square test showed there were no differences between the nuclear family and traditional family mothers in terms of prenatal care and fetal education.

Table 7. Level of First-time Korean Mothers' Planning for Parenthood.

Question	Ratings		% of mothers Total	Nucl.	Trad.
			N=52	N=24	N=28
How well did you plan for pregnancy?	not at all	1	17.3	9.6	7.7
	not much	2	21.2	7.7	13.5
	somewhat planned	3	40.4	23.1	17.3
	very much planned	4	21.2	5.8	15.4
			Number of mothers		
When did you first see a doctor for Prenatal care?	by 4 wks	1	17	8	9
	by 8 wks	2	26	12	14
	by 12 wks	3	4	2	2
	by 16 wks	4	5	2	3
Did you practice fetal education?	no	1	4	2	2
	yes	2	46	22	24

Mothers' Source of Knowledge of Pregnancy and Childcare

What was the major source of knowledge about pregnancy and childcare among first-time Korean mothers? Was there a difference between nuclear and traditional mothers in terms of their sources of information about pregnancy and childcare?

According to Table 8, 19 mothers (36.5 %) reported that their own mothers or mothers-in-law were the primary source of information. Another 36.5% of mothers acquired information about pregnancy and childcare from their sisters, sisters-in-law, or friends, who had experience in

childbirth and parenting. Eleven mothers (21.2%) found books to be their primary source of knowledge. Doctors did not appear to be a significant source of knowledge for mothers in the transition to parenthood (5.8%).

Significant differences were found between two groups on this question. Nuclear mothers seemed to depend more on books and their peer group as the source of information about pregnancy and childcare while the traditional group appeared to use their mothers and in-laws as their source. Chi-square tests were performed between the two groups and show significance differences, χ^2 =14.72, df=7, ** p<.03. Table 8 also shows that majority of mothers (35 mothers) reported that they had not any childcare experiences previously and 16 mothers (30.8%) had previous experiences in childcare. There were no difference between the nuclear and traditional group in previous childcare experiences.

Table 8. Sources of information on Pregnancy and Childcare.

Questions	Rating	Number of mothers Total N=52	Nucl. N=24	Trad. N=28
The source of Information on Pregnancy and Childcare	Books	11	7	4
	Doctors	3	0	3
	Sisters & friends	19	12	7
	Parents & in-law	19	5	14
Previous Experiences in Childcare	Yes 2	16	8	8
	No 1	35	16	19

Social Support

What was the nature and level of social support of Korean first-time mothers? Was there a difference between the nuclear and traditional family mothers in their social support level?

Table 9 indicates that 42% of mothers reported moderate levels of social support while 25 % of them had sufficient levels of support. This support came mainly from their own mothers, their husbands, sisters and sisters-in-laws, and friends. Thirty two percent of mothers reported meager levels of social support. No one reported any support from a social welfare organization.

In terms of the kind of help husbands provided in the postpartum period, mothers reported that most of husbands (77%) helped with rides to the hospital, with changing diapers, and with feeding. A few husbands helped with household tasks including cooking and laundry. The husbands who helped with household tasks in the postpartum period were from the nuclear families.

In the comparisons between the two groups, as shown in Table 10, t-tests reveal a significant difference between the groups in terms of social support ($t = -1.94$, $*p<.05$) and in terms of husbands' involvement ($t = 2.00$, $*p<.05$). The traditional group mothers reported receiving more social support from extended family members than the nuclear group mothers, while the nuclear group mothers reported more

husbands' involvement in childcare activities than the traditional group mothers.

Table 9. Level of Social Support and Husbands Involvement.

Variable	Rate	% of mothers on level of social support Total N=52	Nucl. N=24	Trad. N=28
Level of Support mothers had	0	1.9	1.9	0.0
	scanty 1	3.8	3.8	0.0
	a little 2	26.9	11.5	15.4
	moderate 3	42.3	23.1	19.2
	sufficient 4	25.0	5.8	19.2
Level of husbands' supports	none 0	13.5	3.8	9.6
	1 out of 5 1	32.7	15.4	17.3
	2 out of 5 2	26.7	7.7	19.2
	3 out of 5 3	9.6	3.8	5.8
	4 out of 5 4	13.5	13.5	0.0
	all five 5	3.8	3.8	0.0

Note: 5 categories of husbands' participation for infant care: 1) feeding, 2)bathing, 3) changing diapers, 4) cooking and laundery, 5) giving ride to hospital check.

Table 10. Comparison of Social Support Levels and Husbands Involvement between the Nuclear and Traditional Family Mothers.

Group	Variable	mean	sd	min.	max.	t-value	p
Total (N=52)	Social Support	2.58	.92	0	4		
Nuclear (N=24)		2.58	.97	0	4		
Trad. (N=28)		3.07	.81	1	4	-1.94	.05*
Total (N=52)	Husbands Involve-ment	1.88	1.37	0	5		
Nuclear (N=24)		2.29	1.51	0	5		
Trad. (N=24)		1.53	1.13	0	5	2.00	.05*

Traditional Beliefs and Customs Related to Childbearing

How did first-time Korean mothers value the traditional beliefs and practices related to fetal education, birth, and childcare? Was there a difference between nuclear and traditional family mothers in their level of belief and practices?

Table 11 shows that almost all of the mothers (98%) knew about the traditional teachings of Taegyo. Practically every mother recognized of the presumed importance of Taegyo and a great majority (88%) reported that they practiced teachings of Taegyo. Seventy three percent of mothers said that this was helpful to them in enabling them to cope with stress during pregnancy. In terms of the practice of Taegyo, 21 of mothers (40.4%) reported that they paid special attention to maintaining emotional tranquility, 16 mothers (30.8%) put emphasis on listening to music, and some were particularly careful about their speech (11.5%). Most mothers reported being minimally concerned about traditional food taboos. There was no difference between nuclear and traditional group with respect to their knowledge about Taegyo and their observation of teaching of Taegyo. Both groups practiced fetal education in order to help them cope with stress during pregnancy. Comparing the rural group described by Yu and Kim (1984), this sample of Daegu mothers reported a higher level of knowledge and higher level of practice of Taegyo. Education and the socio-economic status

seem to influence the differences between urban and rural samples in addition to the influence of a rapidly changing society.

Table 11. Percentage of Mothers Who Practiced the Principles of Taegyo (Fetal Education).

Variable	Value	Total	Nucl.	Trad.	Rural
		N=52	N=24	N=28	N=79
Did you know about Taegyo before pregnancy?	no 1	1.9	0	1.9	57.0
	yes 2	98.1	46.2	51.9	43.0
Did you practice Taegyo?	no 1	7.7	3.8	3.8	41.7
	yes 2	88.5	42.3	46.2	58.3
Did it help you to cope with stress during transition?	no 1	7.7	5.8	1.9	
	yes 2	73.1	28.8	44.2	

Concerning mothers' dreams during pregnancy, Table 12 shows that half of the mothers either did not have pregnancy dreams or if they did, did not attribute any profound meaning to them. The contents of the dreams consisted mainly of culturally conditioned traditional images of conception and birth such as snakes, bears, flowers, nuts, fruits, gems, or beautiful garments. Mothers did not report images of celestial bodies, such as the sun, moon, or stars, which are traditionally associated with the birth of great men in Korean culture. Concerning the dreams, no major differences were found between the two groups.

Table 12. Percentage of Mothers Who Had Pregnancy Dreams.

Variable	Rate		Total	Nucl.	Trad.
			N=52	N=24	N=28
Did you have dreams related to pregnancy?	no	1	38.5	21.2	17.3
	yes	2	53.8	21.2	32.6
Did anybody else in the family have similar dreams?	no	1	25.0	13.5	11.5
	yes	2	55.8	21.2	34.6
How did you feel about the dreams?	Happy	1	28.8	9.6	19.2
	Don't care	2	55.7	30.8	25.0
	Not happy	3	15.3	5.7	9.6

Table 13 describes the percentage of mothers practicing the traditional customs for birth and postpartum period. Table 13 shows that very few mothers (3.8) observed Kumjul, the placement of straw ropes across the front gate to prevent unwanted people and evil spirits from entering the house. About one-sixth (17%) reported that their mothers or mother-in-laws prayed to the three shaman goddesses for easy childbirth, but more mothers (30%) were planning to observe samchil, the celebration of the end of the third week after birth, albeit with a simple ceremony. There was significant difference between the two groups on this variable. The traditional group predictably observed the traditional customs more than the nuclear group (Chi square = 12.40, df=5, **p<.02).

Tables 11, 12, and 13 also show the percent of rural mothers who observed the traditional customs reported by Yu

and Kim (1984). This rural sample was made up of mothers in the same age range as the Daegu sample. Although the data were collected in 1984, there were significant difference between this middle-class Daegu sample and the rural sample reported by Yu and Kim.

Table 13. Comparison of the Nuclear and Traditional Group in Terms of the Observation of Traditional Customs.

Variable	Rate		Total N=52 N	%	Nucl. N=24 N	Trad. N=28 N	Rural N=79 %
Praying for easy delivery to Goddess	no	1	43	(82.7)	35	8	39.5
	yes	2	9	(17.3)	2	7	61.5
Prohibiting rope for unwanted visitors	no	1	49	(94.2)	38	6	41.5
	yes	2	3	(5.8)	1	2	59.5
Three weeks Celebration	no	1	38	(73.4)	24	14	
	yes	2	18	(34.6)	2	16	
Have you named the baby yet?	no	1	20	(38.5)	5	15	
	yes	2	27	(51.9)	20	7	

χ^2 =12.40, df=5, **p<.02

Maternal Depression

What was the level of depression among first-time Korean mothers during pregnancy and during the postpartum period? Was there a difference in depression levels between nuclear and traditional family mothers?

Table 14 shows that 69.3% of all mothers had low depression levels, i.e., experienced depressed feelings less

than twice per week. 26.9% of mothers experienced moderate levels of depression, i.e., 3 to 4 times per week, while 3.8% (2 mothers) can be considered to have been clinically depressed during pregnancy. Of the mothers in the higher depression levels (26.9% + 3.8%= 30.7%), only about one-fourth (7.7%) belonged to the nuclear group, while about threequarters of the depressed mothers (23 %) belonged to the traditional group. The mothers at the so-called risk level (3.8% of the total sample) were from the traditional group.

Table 14 also shows that about 53.8% of all mothers had no or little postpartum depression, while 36.5% of the total sample were depressed for several days and 9.6% reported being depressed for more than a week. Of the 46.1% (36.5% + 9.6%) of all mothers experiencing high levels of postpartum depression, i.e., who were depressed for longer than several days, about two-thirds (28.9%) belonged to the traditional group, while about one-third (15.4%) belonged to the nuclear group. Furthermore, 9.6% of the mothers who recorded the most severe level of postpartum depression, 7.7% of them were from the traditional group and only 1.9% from the nuclear group. This constitutes a ratio of 8 to 2.

In Table 15 and Table 16 a similar pattern of depression during pregnancy and postpartum period is found. The mean value of the depression level for the traditional group (16.0) was higher than that of the nuclear group

(13.0), although these differences were not statistically significant. In the postpartum period, the traditional group again recorded a higher levels of depression (9.2) than the nuclear group (7.7). In this case, the difference was significant (t= -o.98, *p<.05).

Table 14. Levels of Maternal Depression during Pregnancy and Postnatal Period

Variables	Rate	% of mothers and rate Total N=52	Nucl. N=24	Trad. N=28
During Pregnancy Had depression less than				
once / wk	0	5.8	3.8	1.9
1-2 times/wk	1-20	63.5	28.8	30.8
3-4 times/wk	21-40	26.9	7.7	19.2
5-7 times/wk	41-60	3.8	0.0	3.8
Postnatal depression				
Not at all	0-4	3.8	3.8	0.0
Less than a day	5-8	50.0	28.8	25.0
For several days	9-12	36.5	13.5	21.2
For more than a week	13-16	9.6	1.9	7.7

Table 15. Group Differences in Maternal Depression Levels During Pregnancy.

Variable	mean	sd	min	max	t-value	p
Total (N=52)	14.6	11.4	0	44		
Nucl. (N=24)	13.0	16.0	0	34		
Trad. (N=28)	16.0	12.4	0	44	-.96	.34

Table 16. Mothers' Postnatal Depression Levels

Variable	mean	sd	min	max	t-value	p
Total (N=52)	8.5	2.8	4	15		
Nucl. (N=24)	7.7	2.4	6	14		
Trad. (N=28)	9.2	2.9	5	15	-.98	*.05

Maternal Self-Esteem

What was the level of self-esteem in this sample of first-time Korean mothers? Was there a difference in the levels of self-esteem among the nuclear and traditional family mothers?

Table 17A shows that 57.7% of all mothers of Daegu sample belonged to the upper range of total score over 100, 32.6% in uncertain middle ground, and 7.7% belonged to the low score group on the Maternal Self-Report Inventory. Half of all mothers had higher scores than the mean score of the total sample.

As shown in Table 17B, the mean score of mothers' self esteem of total group was 102.83 with a range of 68-127. The mean self-esteem score of the nuclear group in this sample is 104.2 with a range of 77-121, while the mean scores of the traditional group is 101.64, with a range between 68-126. No significant difference were found between the nuclear and traditional family mothers in mean maternal self-esteem scores. However there was a wide range of variability in maternal self-esteem scores, especially among the traditional family mothers. Table 17B also showed that the mean of total group (102.83) was lower in comparison with that of the North American subsample, which had a mean score of 109.5, as reported by McGrath for a sample of healthy full-term infants (Mc Grath, 1989).

Table 17. Level of Maternal Self-Esteem of Korean Sample.

Table 17A. Level of the Nuclear and Traditional Family Mothers in the Maternal Self-Report Inventory (Shea & Tronick, 1988).

Score Range	% of mothers Total	Nucl.	Trad.
	N=52	N=24	N=28
68 - 79	7.7	1.9	5.8
80 -100	32.6	15.4	17.2
101 -123	57.7	28.8	28.8

Table 17B. A Comparison of the Nuclear and Traditional Families in the Maternal Self-Report Inventory (Shea & Tronick, 1988) and a Comparison of Korean and N. American Sample. (McGrath, 1989)

Group	N	Range	Mean	sd
Total Sample	52	68-126	102.83	13.29
Nuclear	24	77-121	104.20	11.94
Traditional	28	68-126	101.64	14.44
Korean Sample	52	68-126	102.83	13.29
N. American Sample	36	90-130	109.52	10.13

χ^2= -12.20, df= 87, P<.05

Maternal Adaptation

How did Korean first-time mothers adapt to motherhood and were there differences in the quality of adaptation between the nuclear and traditional family mothers?

According to Table 18, Korean mothers' attitudes toward motherhood is positive. There was no significant difference between the nuclear and the traditional family mothers but the nuclear group recorded a higher mean score with a narrower score range than the traditional group. The Traditional family mothers includes some extremely low

scores on the scale of Shaefer and Manheimer, the Postnatal Research Inventory (1960).

Table 18. Maternal Adaptation of First-time Korean Mothers on the Scale of the Postnatal Research Inventory (Shaefer and Manheimer, 1960).

Group	Mean	sd	Range	t	p
Total (N=52)	108.6	8.4	84-123		
Nucl. (N=24)	109.5	6.9	102-122		
Trad. (N=28)	107.9	9.6	84-123	.68	.498

Marital Relationship

What was the quality of the marital relationship of first-time Korean mothers? How did the quality of the marital relationship differ among nuclear and extended family mothers?

Table 19 shows that 26.9% of all first time Korean mothers described their marital relationship as being very happy and 65.4% of them described it as happy. Only 3 persons described their marital relationship as being neutral and uncommitted, while 1 person viewed her relationship as being unhappy. There was no significant difference between the two groups in terms of their levels of marital satisfaction.

Table 19. Ratings of the Marital Relationship in First-time Korean Mothers.

Variable	Value	% of mothers Total N=52	Nucl. N=24	Trad. N=28
Marital Relation-ship	very unhappy 1	0.0	0.0	0.0
	unhappy 2	1.9	1.9	0.0
	so & so 3	5.8	3.8	1.9
	happy 4	65.4	34.6	30.8
	very happy 5	26.9	7.7	17.3

Breast Feeding and Rooming Arrangements for Infants

How did first time Korean mothers adapt to breast feeding and rooming-in with their babies? Were there differences between the nuclear and traditional family mothers in these practices?

Table 20 shows that a half of the mothers (50%) rotated breast feeding with bottle feeding, 25% used breast-feeding only, and 25% bottle-fed their babies. There was a significant difference between the nuclear and traditional groups in their feeding practices (χ^2=7.61, df=3, *p<.05). Breast-feeding was more common among mothers of the traditional group while nuclear mothers preferred bottle-feeding their babies.

All the mothers, except the breast-feeding mothers, expressed problems with feeding, such as pain (40.4%), difficulty in suction problem (21.2%), and insufficient lactation (15.4%). Forty-two percent of the mothers intended to breast-feed their babies up to 6 months, 25% up to 8 months, and 9.8% longer than one year. There was a

significant difference between the two groups in this regard: more mothers in the traditional group intended to breast-feed for a longer period than the nuclear family mothers (χ^2.=11.5, df=6, *p<.05). The rural group by Yu and Kim shows a much higher level and longer period of breast-feeding practices.

Table 21 demonstrates that almost all of the first-time Korean mothers retained the tradition of keeping their infant babies in the same room as themselves (90.4%) and preferred to lay the babies in a supine position (80.8%) in order to avoid suffocation. They swaddled their infants very firmly. There was no significant difference between the two groups in terms of sleeping arrangements for the infants.

Table 20. Feeding Practices of First-time Korean Mothers.

Variable	Value	% and number of mothers Total N=52		Nucl. N=24	Trad. N=28	Rural N=79
Feeding Type						
		N	(%)	N	N	%
Breast	1	13	(25.0)	3	10	58.2
Bottle	2	9	(17.3)	4	5	7.6
Combined	3	26	(50.0)	13	13	34.2
Intend to Breast-Feed						
Less than 1 month	1	5	(9.6)	5	0	0.0
Up to 6 months	2	22	(42.3)	9	13	18.9
Up to 9 months	3	13	(25.0)	6	7	
Up to 1 yr	4	4	(7.7)	0	4	41.8
More than 1 yr	5	1	(1.9)	1	0	39.3

χ^2=7.61, df=3, *p<.05 between nuclear and traditional mothers
on feeding type.

Table 21. Rooming Arrangements for Infants.

Variable	Rate		Total N=52	Nucl. N=24	Trad. N=28
Rooming-in	No	1	9.6	5.7	3.8
	Yes	2	90.4	40.4	50.0
Position	Prone	1	11.5	5.7	5.7
	Supine	2	80.8	34.6	46.2

Correlational Results

Table 22 provides the correlational analysis between selected variables: Planned Pregnancy, Feelings about Pregnancy, Feelings about Motherhood, Feelings about Demands of Childcare, Fetal Education, Breast Feeding, Maternal Depression in Pregnancy, Postnatal Depression, Maternal Adaptation, and Maternal Self-esteeem.

Planning Pregnancy was significantly correlated with feelings toward pregnancy (r=.29*), duration of rarriage (r=.34*), breast feeding (r=.40**), and fetal education (r=.30*).

Feeings toward Pregnancy was significantly correlated with Planned Pregnancy (r=.29*), Maternal Happiness (r=.30*), and Marital Satisfaction (r=.41**).

Maternal Happiness was significantly correlated with Feelings toward Pregnancy (r=.30*), Duration of Marriage (r=.35*), and Fetal Education (r=.46**), and had strong negative correlations with Depression during Pregnancy (r=-.43**) and Depression after Delivery (r=-.44**).

Marital Relationship was correlated strongly with Feeling toward Pregnancy (r=.41**), Maternal Happiness (r=.35**), Mothers' Relationship with their own Mothers (r=.34*) and Fetal Education (r=.40*), and had invertly correlated at significant level with Depression during Pregnancy (r=-.56**) and Depression after Delivery (r=-.36**). Duration of Marriage was significantly correlated with Planned Pregnancy (r=.35*) and Breast Feeding (r=.31*), and had negative correlation with Social Support (r=-.35*).

Social Support was negatively correlated at significant level with Mothers' Age (r=-.30*) and Income (r=-.31*).

Depression during Pregnancy was significantly correlated with Depression after Delivery (r=.63**) and had significant invert correlations with Maternal Happiness (r=-.43**), Marital Satisfaction (r=-.56**), and Maternal Adaptation (r=-.39**).

Depression after Delivery was strongly correlated with Depression during Pregnancy (r=.63**), and had strong invert correlations with Maternal Happiness (r=-.44**), Marital Satisfaction (r=-.36**), Maternal Adaptation (r=-.59), and Maternal Self-Esteem (r=-.37**).

Maternal Adaptation was strongly correlated with Maternal Self-Esteem (r=.39**), and had strongly negative correlations with Depression during Pregnancy (r=-.39**), and Depression after Delivery (r=-.59**).

Maternal Self-Esteem was strongly correlated with Maternal Adaptation (r=.39**), and negatively with Depression after Delivery (r=-.37**).

Stressful Feelings due to Childcare after Delivery was negatively correlated at significant level with Social Support (r=-.30*), and Mothers' Age (r=-.29*).

Table 22. Correlational Results between Selected Variables.

Pearson Correlations r=

Variable	A	B	C	D	E	F	G	H	I	J	K	L	P
A		.2853*			.3434*								
B	.2853*		.2989*	.4066**									
C		.2989*		.3464**				-.4271**	-.4369**				
D		.4066**	.3464*			.3366*		-.5577**	-.3577**				
E	.3134*												
F				.3366*									
G					-.3448*							-.3000*	-.2961*
H			-.4272**	-.5577**					.6289**	-.3851**			
I			-.4369**	-.3577**				.6289**		-.5894**	-.3675**		
J								-.3851**	-.5894**		.3836**		
K									-.3675**	.3836**			
L							-.3000*						-.2989*
M							-.3098*						
N	.3993**				.3035*								
O	.3061*		.4453**	.3921*									
P							-.2961*					-.2989*	

A) Planned Pregnancy, B) Feelings about Pregnancy, C) Feelings about Motherhood, D) Marital Relationship,
E) Duration of marriage, F) Mothers' relationship with their own mothers, G) Social support,
H) Depression in pregnancy, I) Postnatal depression, J). Maternal adaptation, K) Maternal self-esteem,
L) Mother's Age, M) Income, N) Breast feeding, O) Fetal education, P) Feelings about Demands of Childcare.

CHAPTER 5

DISCUSSION

"Only through childbirth, does a person become a real woman." This Korean folk saying suggests that in Korea, where procreation and family life are highly valued, becoming a mother for the first time functions as a major developmental transition in a woman's life-cycle.

While there have been many studies of the transition to parenthood in the cultural context of Western societies, few studies have been conducted in Korea. This study was designed firstly to examine the process of the transition to parenthood and thereby contribute to a greater theoretical understanding of this transition. Secondly, by providing information on the transition to parenthood in Korean society in particular, this study should contribute to the documentation of variation in the cross-cultural understanding of parent-child relations.

The goals of the present study were: 1) to describe the experiences of first-time Korean mothers during the transition to parenthood, and 2) to compare the experiences of first-time Korean mothers within nuclear families with the experience of mothers living in traditional family settings. Finally, these results will be used to provide a data-base for a program of preventive intervention for Korean mothers, especially for first-time mothers and their infants.

According to the data reported here, a great majority of first-time Korean mothers in the present study had their first babies as soon as they were married. The decision to become pregnant was related to age ---their own and, especially, their husbands' age. Motivation for pregnancy was high because most of the fathers married late, and the strong motivation can also be seen as a response to their in-laws expectations of grandchildren. The majority of the mothers in this sample had well planned pregnancies and had positive attitudes toward pregnancy and towards becoming a mother. The majority of the mothers were well prepared for pregnancy both in terms of having good prenatal medical care and in terms of maintaining the traditional Korean cultural practice of fetal education, Taegyo at the beginning of pregnancy. A great majority of mothers began prenatal care as early as 8 weeks and practiced Taegyo during pregnancy. This was true of mothers in both the nuclear and traditional families.

Mothers who planned their pregnancies had more positive feelings about their pregnancies, and were most likely to practice fetal education and to prolong breast feeding in the postnatal period. This suggests that mothers who planned their pregnancies were better able to cope with the difficulties of pregnancy and were more likely to adapt positively to their maternal roles postnatally. These findings are consistent with findings in the literature,

which link prenatal care with positive maternal adaptation (Doering and Entwisle, 1975; Daniels & Weingarten, 1982; Russell, 1974; Sherefsky & Yarrow, 1973).

Most mothers in this study reported being happy during their pregnancy and also reported that they were very pleased with becoming a mother. However, in the postnatal period, these same mothers also experienced the transition as moderately stressful, due to the demands of childcare after delivery and due to physical fatigue. They were distressed by the baby's demands and by their lack of knowledge about childcare. Only one fifth of the mothers in the total sample reported that their transition to parenthood was smooth. There were no differences between the nuclear family mothers and the traditional family mothers, despite the fact that the nuclear family mothers were not isolated at this time, since they invited their own mothers and mothers-in-law to their homes to help after delivery. Nevertheless, the care of the newborn was a stressful experience for most mothers in this sample.

One of the goals of this study was to examine the sources of information on pregnancy and childcare available to Korean mothers of today. One third of the mothers received this information from their own mothers, a third were given information by their peer group, while the rest read the information in books published by baby-formula companies. A majority of the mothers acknowledged that the

information they received about pregnancy and childcare was inadequate. Today's young Korean mothers are more educated than their own mothers. They want more information on pregnancy and childcare, and they tend to look towards modern medicine and their peer group or books for this information. The mothers, reported however, that professional people provided minimal information, despite the frequency of the check-up visits. Mothers themselves expressed their reluctance to ask questions because of the unsympathetic or rude attitude of doctors. Considering the demanding schedules of medical doctors in large Korean hospitals, however, this lack of support is understandable.

Half of all the mothers in this sample lived close by their parents or parents-in-law, and the other half of the sample lived as couples in the city, separate from their families of origin. Almost all of the mothers in the total sample had frequent contacts with their parents-in-law, but more mothers reported having a closer relationship with their own parents during pregnancy, childbirth, and during the postpartum period. The study revealed that the nuclear family mothers in Korea are not isolated from their families in the same way as mothers living in North American nuclear family settings are. In contrast to the traditional Korean practice, in which the father-son relationship was at the core of family life, it is reported that modern nuclear family mothers receive more support from, and have closer

contact with their own families than from and with their in-laws (Lee, 1991).

The majority (two thirds) of mothers in this sample reported that they had moderate levels of social support during this transition period, while one third of the mothers said they received insufficient support. The study revealed that the network of mothers' social support was informal, coming from immediate family members, especially their own mothers, mothers-in-law, sisters or friends. A few nuclear family mothers had paid helpers, but no one had any support from a social welfare organization. The nature of the support consisted mainly of advice and information on pregnancy and childcare, and came equally from sisters, friends, and their own mothers. Husbands tended to provide encouragement, while the mothers' own mothers provided both moral and instrumental kinds of support.

Regarding the husbands' involvement during the postpartum period, a majority of husbands demonstrated a low level of involvement in childcare. This may be due to the following reasons: 1) In traditional Korean society, men's involvement in childcare and household chores was regarded as shameful. Men refrained from expressing affection, even holding their own children in the presence of the elders. In response to the question, "Does your husband help you with childcare?", one mother giggled as she imagined her husband doing childcare and replied, "He is not that kind of

person. He just is not." 2) Even now, as this study shows, despite the fact that all of the mothers viewed husbands' involvement in childcare as natural and necessary, most of the mothers consider childcare their own territory and consider husbands only as helpers, and not dominant figures. The mothers reported that their husbands tended to be rough and inefficient in taking care of babies. 3) Since the husbands' work is the primary source of family income for most of the families, many mothers were concerned that childcare would place an additional burden on their husbands. Generally, husbands are perceived by mothers as the source of emotional and moral support.

The level of Korean husbands' involvement in childcare, other than providing moral support, is generally meager, although this study suggests that this may be changing. The findings in this study did show a wide range of levels of spousal support during the transition to parenthood and a higher level of involvement in nuclear families as compared to traditional families. Husbands were seen as important helpers by their wives. A few husbands in the nuclear family group, provided intensive support at home, by doing household chores. Other mothers reported that their husbands contributed by giving them rides to their hospital visits or by helping feed the baby occasionally. However, in general fathers in traditional families were minimally involved in childcare. It may be that because of the active involvement

of their own parents in childcare, most of the traditional family husbands did not have to do so.

Children's opportunities for development may depend on the extent to which other people present in the environment support or neglect the new parents (Bronfenbrenner, 1979). Social network theories presuppose that social support will influence on maternal behavior in ways beneficial to the accomplishment of one's role as a mother (Crockenberg, 1981). Social support provides help for maternal adaptation, and social support has been found to correlate positively or negatively with the level of maternal depression depending on the nature of that support. One important factor, as Crokenberg has pointed out, is whether the mother perceives the support as helpful or not. If the support is unwanted, or comes from the wrong person, a mother may view it as irritating and stressful rather than as supportive. The traditional mothers in this sample, for instance, had adequate family support from their family members, but they were also more depressed. This can be explained by the fact that these new mothers often experienced stress in the presence of their mothers-in-law, and seemed to be undermined by them.

In general, this study showed that social support was related to the reduction of stress, the mother's age, and the duration of the marriage. Mothers who were older and married longer may be better settled into their married

lives, and may therefore respond more confidently to the division of household labor. They in turn can lead more independent lives with less dependence on social support than the younger or newly married mothers.

One of the central goals of this study was to examine the influence of traditional belief systems and customs on the transition to parenthood in modern Korean society. Concerning certain traditional beliefs and customs related to childbirth, a great majority of mothers in both groups believed in the importance of the practice of Taegyo during pregnancy. Their concerns and efforts for fetal development were equally manifested by mothers in nuclear and traditional group. There was no difference between the two groups on this issue. This was not true of the attitude towards dreams. Fewer nuclear mothers than traditional mothers reported having dreams related to pregnancy and childbirth. Furthermore, fewer nuclear mothers entertained either happy or unhappy feelings about the dreams they did have. The fact that only one-third of the nuclear group relied on pregnancy dreams for guidance, while more than half of the traditional group did, implies that the nuclear mothers were more independent and relied more on their own internal resources or forces within their own control, while the traditional mothers relied more on external entities, whether dreams or other extended family members, as sources of support and guidance during pregnancy.

Prenatal customs, such as praying to a goddess for an easy delivery and the use of the prohibition rope, were not as common in this sample. The custom of naming the baby usually took place some months after delivery, whereas a majority of the nuclear family mothers in this sample named their babies within one week after delivery. These changes can be interpreted as due to the decrease in infant death rates, as well as the benefits of modern medicine. These findings clearly indicate that while nuclear family mothers observed the traditional customs, they also seemed to display more autonomy in their use of customs than did the traditional family mothers.

One third of mothers in this Korean sample described some level of prenatal depression. There were no statistical differences between the nuclear and traditional mother groups in levels of depression. However, the mothers experiencing the highest levels of depression belonged mostly to the traditional family group. In other words, mothers living in the traditional family settings were more depressed during pregnancy than mothers living in nuclear settings. During the postpartum period, some mothers again experienced high levels of depression lasting for more than several days. The traditional mothers consistently demonstrated higher levels of depression, and two mothers in this group even reached a level of clinical risk based on their CES-D scores, despite the fact that traditional

mothers received a greater amount of social support from their extended family. This disparity between social support and depression may be due, as was pointed out earlier, to discordant family relationships in traditional families, particularly relationships between mothers-in-law and new mothers.

The maternal self confidence of the nuclear mothers in this Korean sample was higher than that of the traditional mother in the sample, but was lower than that of the North American sample reported by McGrath (in press). The traditional mothers had lower self-confidence than the nuclear family mothers. This may be because the traditional family mothers were usually living in an extended family setting, where the patriarch male-heir line was all-decisive, and where the mother-in-law imposed influential power over childcare. This tends to leave the traditional mother in a subservient role, with little opportunity to build up her feelings of self-confidence through parenting.

The lower self-esteem level of this sample as compared to the North American sample can be interpreted in many ways: 1) The literature suggests that the timing of the assessment, sample differences, cohort effect, and the age of the child can be variables that influence maternal self-esteem ratings (Cowan & Cowan, 1988). In previous studies, women's average ratings of self-esteem dropped from pregnancy to the first few weeks after birth and returned to

their original levels by 1 year postpartum (Reilly, Entwisle, & Doering, 1987). While the women in this Daegu sample consisted of all first-time mothers assessed 1-2 weeks after delivery, the North American sample included both new and experienced mothers. 2) Many mothers in Daegu sample reported an insufficiency of information about pregnancy and childcare, and a lack of previous childcare experiences, and this may have contributed to the lower levels of self-esteem. 3) Another possible explanation for this finding is the fact that the Koreans in general, and therefore the respondents in this Daegu sample in particular, may be culturally more reticent about themselves and their capabilities than respondents in comparable North American samples. 4) Another possible interpretation is that Korea on the whole is still a very male-oriented society and this might contribute to the relatively low score on maternal self-esteem. 5) Finally, the measure of self-esteem for Korean mothers, itself may not be valid, since it was standardized on a North American sample. Further research is necessary to test the validity of this finding for a Korean sample.

In terms of maternal adaptation and the quality of the marital relationship, family structure did not appear to be of critical importance. Most of the mothers in both groups reported their married life to be as happy and the mothers well adapted successfully to the tasks of motherhood.

Mothers' previous psychological experiences, as well as their relationship with their own mothers, affected their marital relationships. Furthermore, mothers who reported happy marriages were more positive about their pregnancies and about their transition to parenthood. They were also more likely to practice fetal education. Finally, these mothers were less depressed during pregnancy. These results confirm findings from studies conducted in North America, linking the quality of the marital relationship with positive postnatal parent-child relations (Nugent, 1991).

This study also examined the feeding and sleeping patterns of Korean mothers in the newborn period. Half of the mothers in this sample rotated breast-feeding with bottle feeding, 25% used bottle-feeding exclusively, and only 25% used breast-feeding only. Almost all of the mothers kept their babies in the same room day and night. A few working mothers made arrangements for their babies to stay with the grandmother at night during the postpartum period.

Breast feeding was another point of departure for the two groups of mothers in the study. While the nuclear mothers reported various problems associated with breast-feeding, such as pain, difficulty in suction, frequency of feeding, and insufficient lactation, and wanted to shorten the period of breast-feeding, the traditional family mothers were more likely to lengthen the period of breast-feeding.

In all probability, the traditional family mothers also suffered from the same problems as the nuclear family mothers, but because breast-feeding is an old tradition, and an experience cherished by their mothers-in-law or by their own mothers, they choose to breast feed. In extended family settings, daughters-in-law are usually burdened with much household work. It may be that the very act of breast-feeding could also allow them a sense of their freedom and independence, albeit briefly, since parents-in-law or other members of the extended family would neither bother them nor require them to do other household work during breast-feeding.

Most of the mothers in the sample slept with their infants in the same room, not because of their one-room home, but because they felt secure following the traditional custom of physical proximity with their infants, which they believed would help foster the attachment relationship between mother and infant.

Finally, it can be pointed out that while many of the factors influencing the transition to parenthood in this study were unique to Korea, the findings also replicated results found in studies conducted in North America and elsewhere. This study showed that Planned Parenthood was related to positive attitudes towards motherhood and better adaptation to the maternal role (Russell, Sherefsky and Yarrow, 1973); and mothers who are older and married longer

adapt better to motherhood (Hobbs and Wimbish, 1977; Daniels and Weingarten, 1973).

In this study marital satisfaction has been found to be an important and influential factor in enabling mothers to make a smooth transition to parenthood (Cowan & Cowan 1988; Belsky, 1983). Marital satisfaction was correlated with maternal happiness both during pregnancy and after delivery, and with the practice of Taegyo. It correlated negatively with maternal depression during both pregnancy and the postpartum period. The finding that marital satisfaction was related to mothers' relationship with their own mothers coincides with findings from a number of other studies (Cohen, 1966; Belsky, 1983; and Bibring,1959). Cohen reported, for example, that mothers who report good adjustment during the transition to pregnancy were those who came from harmonious homes and had good relationships with their own mothers. In this study, maternal depression was related to low maternal self-esteem in the postpartum period, and to poor maternal adaptation during pregnancy. Taegyo was also related to maternal happiness and marital satisfaction. Of all the relationships, it seems that mothers' psychological health and marital satisfaction were at the core of the transition process.

Conclusion

In conclusion, this study shows that, in general this sample of first-time Korean mothers living in the city of

Daegu experienced moderate levels of stress during the transition to parenthood. They experienced more stress after delivery, because of the tasks of caregiving. However, planned pregnancy, support and expectations of family members, combined with the mother's own positive feelings and positive attitude toward pregnancy and motherhood, seemed to moderate the difficulties they experienced in caregiving.

Increasingly, young couples in Korea are choosing their own mates, and are choosing to live in nuclear family settings away from the residence of their family of origin. The urban nuclear family is becoming the basic unit of Korean society. This study suggests that this trend brings both advantages and disadvantages to new parents going through the transition to parenthood. The Korean custom of having childbirth and confinement at the mothers' own parents' home is in the process of fading away and being replaced by a new trend: young couples living in nuclear family settings, having the transition to parenthood at their own home, and inviting their own mothers or other experienced women for support. So, although they live in a nuclear setting, these families are not actually isolated. The majority of mothers living in nuclear family settings had close contacts with their family of origin during pregnancy. Nuclear family mothers in this study were more autonomous and self reliant, had higher levels of self

esteem, and were less depressed than mothers in the traditional family group. However, the nuclear family mothers also felt some stress, perhaps because of their relative isolation and the demands of the decision making process involved in parenting.

Mothers living in traditional family settings showed a stronger tendency to follow traditional beliefs and practices during the transition to parenthood, and they enjoyed more support from extended family members. Some mothers who stayed with their in-laws perceived this help as supportive, while others saw it as intrusive. This depended on the nature of intergenerational understanding, and the nature of their relationship with the mother-in-law. While these mothers were more likely to receive good modeling from an experienced mother-in-law, they often felt limited in their opportunity to make decisions about their infants, and their self-esteem may have suffered as a result.

In general, first-time Korean mothers in this study accommodated traditional beliefs and practices and integrated them into their lives. The variable that predicted the integrated use of traditional customs was the mother's education level, a result also revealed in the comparison with the rural sample (Yu & Kim, 1984). Mothers in the present study sample discarded some scientifically unreliable taboos and integrated the principles of Taegyo with findings from modern medicine or modern psychology,

with regard to diet and emotional stability. Taegyo (fetal education) and traditional mother-infant sleeping arrangements are still practiced universally, although some traditional practices and beliefs seem to be in decline in modern Korea. To aid the development of the next generation, professionals should help ensure continuity between the old and the new through educational programs. For that purpose, more research is needed to examine the factors that affect mother's decision-making in her parenting role in Korean society.

Over the past three decades, modern Korean women have enjoyed the benefits of modern legal reforms and social changes. They now have status and position in the family. They may choose their own mates and start married life by themselves, usually in a small apartment in the city. But this freedom and independence should not be considered in the conventional Western sense. There are still strong pressures on the couple from extended family and from social groups. The patriarchal household has lost its legal authority, but the husband-wife relationship still does not function as the main force. The teaching role of grandparents has been weakening, especially in terms of the sex education of the younger generation. Sexual freedom reflecting western cultural values has been introduced, and childbearing is now considered by many as a medical matter.

To facilitate the development of positive parent-child relationships in modern Korea, and in order to meet the needs of the increasing number of parents living in nuclear families, educational programs should both make use of and adapt traditional Korean customs and beliefs, which in turn should help establish continuity between the old and new generations, and thus benefit future generations of Koreans.

Implications for Further Study

Generally it is understood that social support during the transition to parenthood should lessen maternal distress. One of the interesting findings in this study is that some mothers who stayed at the homes of parents-in-law were depressed despite the social support network of the extended family members. The phenomenon of maternal depression needs further study. The literature suggests that mothers---and especially first-time mothers---experience some degree of depressed feelings after delivery because of maternal hormonal changes (Hopkins et al, 1984), and Cutrona (1982) reported that 50-70% of mothers experience depression after delivery, while that figure drops to about 33% in the first week postpartum. But the significant group difference between the nuclear and traditional family mothers in this study is compelling enough to suggest the need for further study.

Further research on maternal self confidence in Korean first-time mothers is also warranted. The finding of this

study showed that the level of maternal self-esteem as measured by the Maternal Self Report Inventory (Shea & Tronick, 1989), was lower than that of a North American sample (McGrath, 1989). Despite the level of preparedness of the Korean mothers, their positive feelings and attitudes toward pregnancy and motherhood, their having full term healthy babies and their high level of social support, the maternal self-esteem level was expected to be at least as high as in the North American sample. However, the timing of assessment, cohort effect, sample differences, and the age of the child can be variables that influence maternal self-esteem ratings. In general, further study is needed to test the validity of these preliminary results and this explanation.

Recommendations

The transition to parenthood can be seen as a sensitive period in the emerging parent-child relationship, and may be an optimal time for intervention (Nugent & Brazelton, 1989). It is the beginning of the parent-infant relationship, and at this time parents and child begin to exchange their first communication signals as their relationship begins to develop. Early intervention as prevention can be divided into three categories: primary, secondary, and tertiary prevention (Leavell and Clark, 1965) and since primary intervention is practiced prior to the origin of problems, it is most the most desirable. For the present sample of

first time mothers, as a non-risk group, a preventive educational and supportive parent program is recommended.

The importance of parent education in Korea has been recognized and especially emphasized since the 1980s, when early childhood education became a focus of attention at the governmental level. The program is designed primarily for parents of preschool children, with nothing for infants. University-based adult education offers childcare courses for future mothers, but only in didactic form. More systematic and longterm parent education programs, which combine the theory and practice of parenting to prepare parents are needed.

Such education/support programs should be designed to provide information about pregnancy and childcare as well as providing opportunities to share experiences with other parents-to-be. Arrangements at the community level, such as in churches or schools, may be the best channels of communication for young mothers, allowing them to establish networks of support among themselves.

The integration of modern medicine and traditional wisdom is recommended as the central focus of the parent education program. For that purpose, the program should be carried out by professionally trained personnel.

Considering Korean mothers' trust in professional people, such as doctors or nurses, it can be argued that hospital-based parenting programs would be the most

effective form of parent education. These should be conducted during pregnancy and during the hospital stay, and should include information about and actual demonstrations of early infant care. Research has shown that, especially during the hospital stay of one or two days, a brief intervention demonstrating the newborns' behavioral repertoire for the family as a whole can be helpful for the parent-child relationship (Nugent and Brazelton, 1989).

Inclusion of other members of the family, especially husbands, in the educational programs is strongly recommended. The family is the major context for the growth of the new mother-child relationship. In traditional society, Korean fathers provided strong moral support during pregnancy, but they were not involved in childrearing until the child was ready to learn to read. Today, in the modern Korean family, the male is under strong pressure to become a good "organization man," and as a consequence, men spend a great deal of their time at their work place or in work-related social activities. Due to rapid changes in family lifestyle in Korea, young mothers should expect even more difficulties in the future. Today, young mothers no longer see men's involvement in childcare as shameful, but rather as natural and desirable, for both the child and the couple themselves.

At the policy-making level, this study suggests that the maternity leave of one month for working mothers should

be extended for the sake of the mother-infant relationship. There should be a policy that guarantees the mother's job, and includes some extension of the leave of absence, if a mother so wishes. It should be pointed out that some working mothers in this sample expressed feelings of guilt about being separated from their infants, and reported that they felt they were missing precious experiences with their children. However, all of the working mothers in the sample were able to make childcare arrangements with their own mothers or mothers-in-law, or with someone related to the family.

If it is true, as Klaus and Kennell (1976) argue, that the first hours after birth constitute the most sensitive period for maternal bonding and may have long-term effects, hospital arrangements for newborn care and guidelines in feeding should be modified accordingly. At present mothers and infants are separated after birth, and infants are kept in separate nurseries. Feeding is begun with bottle feeding at the hospital. Research shows that a rooming-in arrangement in the hospital after delivery promotes breast-feeding among new mothers (Reiff & Essock-Vitale, 1985). For attachment relationship between mother-baby hospital policy on the first feeding and hospital policy on rooming-in should be reexamined in Korea.

A home-visiting program would also be most beneficial for first-time Korean mothers, so that experienced or

professional people could support new mothers, especially those living in nuclear family settings. In addition to the relative lack of mobility experienced by many new mothers in later pregnancy and during the first month of post-delivery, home visiting programs can identify unique problems for individual mother-child situations. Furthermore, most of the mothers in this research expressed reluctance at sending their infants to childcare institutions, at least before the child reached the age of three. It is evident that Korean mothers want to be with their children, although this finding may reflect the demographic nature of the sample, which was middle-class and relatively well-educated. Home visiting programs can be extended to train experienced women to help new mothers like their own mothers, or grandmothers, who can serve in the role of Doula as practiced in many Spanish-speaking cultures (Jordan, 1980).

Given the demographic changes in Korean society, it is fairly urgent to provide home-like public infant care facilities for nuclear family working mothers, who live away from their families and may lack social support from their own families. In sum, it should be a primary concern of parent education programs to aid in the transition to parenthood in modern Korea by developing the possible strengths that a nuclear family life-style offers, without breaking the continuity of tradition found in extended traditional Korean family life.

In Korea, the transition to parenthood is itself embedded in a larger cultural transition, the transition from the traditional world to the world of modern technology. This societal transition also involves a transition in family structure, from the traditional extended family life to life in modern nuclear families. Young parents today need to evaluate those changes. On the one hand they need to respect traditional beliefs and practices, and on the other hand they need to be able to integrate modern psychology and medicine into their parenting. This study suggests that a preventive educational program that supports this integrative approach to parenting should play an important role in the lives of Korean parents and their children in this time of rapid social change.

APPENDICES

APPENDIX A

HOSPITAL POSTNATAL INTERVIEW QUESTIONNAIRE

Directions: Because we are trying to learn as much as we can about the health and concerns of first time mothers during pregnancy. I would like to ask you some questions about yourself and your pregnancy. All the information you give will remain confidential. Your name will not appear in any report. Some of the question may not seem to apply to you since we are asking these questions of many mothers of different ages and backgrounds. If there are any questions you prefer not to answer, just tell me and I will omit them.

Prenatal Experiences

Firstly, I would like to ask you some questions about yourself.

ID. Your name
A1. How old are you?_____
A2. 1.( ) married 2.( ) unmarried
A3. What is your present address?_____
A6. How long have you been living there?_____
A7. Who else lives there? 1.( ) husband 2.( )parents-in-law 3.( )parents 4.( )siblings-in-law 5.( )siblings 6.( )other
A8. What is your education level? 7.( )doctorate 6.( )master 5.( )college 4.( )jr.college 3.( )high school 2.( )middle school 1.( )elementary school

A9. How many brothers and sisters do you have and what is your place in order? ( ) brothers and sisters order( )
A10. Are you working now? 2.( )yes 1.( )no
A11. On the whole, how do you feel about your job?
5.( )very satisfied 4.( )satisfied
3.( )mixed feeling 2.( )dissatisfied
1.( )very dissatisfied
A12. If not working, would you prefer to have job?
2.( )yes 1.( )no
A13. Did you quit after pregnancy? 2.( )yes 1.( )no
A14. Do you plan to go back to work after the baby is born?
2.( )yes 1.( )no
A15. If yes, when?
5.( )as soon as possible 4.( )after baby 1 year old
3.( )after baby kindergarten 2.( )after child in school 1.( )much later
A16. Who will mind the baby then?
4.( )mother 3.( )mother-in-law 2.( )relatives
1.( )none
A17. Would you use day care facilities? 2.( )yes 1.( )no

A18. What is the reason?
1.( )must be mother's care 2.( )cannot trust
3.( )reluctants

I would like to ask you a few questions about the baby's father.

B1. How old is he? ( ) years old
B2. If married, how long have you been married? ( )years
B3. Where does he live?
2.( )same address 1.( )other place
B4. Why is that so? 1.( )job
B5. What is his education level?
7.( )doctoral 6.( )master 5.( )college
4.( )jr.college 3.( )high school 2.( )middle school
1. ( )elementary school
B6. What is his occupation?
5.( )professional 4.( )semi-prfessional
3.( )business owner 2.( )labor 1.( )other
B7. What is your monthly income?
1.( )$1000 or below 2.( )$1000-1300 3.( )over $1300
B8. Would you tell me how your marriage happened?
1.( )love 2.( )arranged marriage 3.( )half and half
B9. What was your parents' attitude toward your marriage?
2.( ) oppose 1.( )agree
B10. How do you consider your married life to be?
5.( )very happy 4.( )quite happy 3.( ) so and so
2.( )quite unhappy 1.( ) very unhappy

Would you mind if I asked you a few questions about your parents?

B11. How well do you get on with your mother?
4.( )very well 3.( ) well 2.( )not very well
1.( )not well at all
B12. Do you think you have your mother's mothering in you?
2.( ) yes 1.( )no
B13. Would you like to be a mother like your mother to your baby?
2.( )yes 1.( )no
B14. Where do they live? 1.( )Daegu 2.( )other city
B15. How often do you contact them?
6.( )every day 5.( )1 or 2/wk 4.( )1 or 2/month
3.( )bimonthly 2.( )special occasions 1.( ) none
B16. Did you have more contact since pregnancy?
3.( )more 2.( )same 1.( )less
B17. Did you discuss your pregnancy with your mother?
2.( )yes 1.( )no
B18. How well do you get on with your mother-in-law?
4.( ) very well 3.( ) well 2.( ) not very well
1.( )bad
B19. Where do they live? 2.( )same city 1.( )other

B21. How often do you contact them?
6.( )everyday 5.( )1 or 2/wk 4.( )1 or 2/month
3.( )bimonthly 2.( )special occasions 1.( )none
B22. Do your parents-in-law or your parents help you financially?
2.( )yes 1.( )no
B23. How is your present financial condition?
5.( )very satisfied 4.( )satisfied 3.( )so so
2.( )poor 1.( )very poor
B24. Do you help your parents-in-law financially?
2.( )yes 1.( )no
B25. Does it bother you?
5.( ) very much happy 4.( )quite happy 3.( )nuetral
2.( )somewhat unhappy 1.( )very unhappy
B26. Do you help your parents financially?
2.( ) yes 1.( ) no
B27. Does your husband know it? 2.( )yes 1.( )no
B28. Doew it bother you?
5.( )very much happy 4.( )somewhat happy
3.( )nuetral 2.( )somewhat unhappy 1.( ) very unhappy
B29. What do you think about nuclear family?
1.( ) anti 2.( ) pro 3.( )I don't know
B30. If pro, why? 1.( )intimacy 2.( )freedom
3.( )conflict between generations 4.( )comfortable
B3^U^^* ' (*^U^^^S why? 1.( )financial benefit
2.( ) childcare help 3.( )psychological safety

Health Care

C1. When did you first see a doctor about your pregnancy?
_____ week
C2. How many visits have you had?_____
C3. Do you get informations on pregnancy from your doctor?
2.( )yes 1.( )no
C4. With whom do you have necessary consultation during pregnancy? 8.( )mother 7.( )mother-in-law
6.( )friends 5.( )doctors 4.( )sister (in-law)
3.( )mass com. 2.( )books 1.( )other
C5. Do you think you need antenatal classes?
2.( )yes 1.( )no
C6. Do you think your husband should attend the classes?
2.( )yes 1.( )no
C8. Do you smoke? 2.( )yes 1.( )no,
if yes, how much?_____
C9. Do you drink? 2.( )yes 1.( )no,
if yes, how much?_____
C10. What kind of drink do you have?
1.( )beer 2.( )Soju 3.( )wine 4.( )rice wine
5.( )scotch 6.( )other
C13. Did you use any other drugs or tablets?
2.( )yes 1.( )no
C14. If yes, what did you use? 4.( )sleeping pill
3.( )sedatives 2.( )opium 1.( )other

C15. Since your pregnancy, which beverage do you usually have? 1.( )beer 2.( ) Soju 3.( )wine 4.( )rice wine 5.( )scotch 0.( )none

Experiences in pregnancy

C16. Before you got pregnant, how much had you planned to get pregnant? 4.( )planned very much
3.( )somewhat planned 2.( )had not planned much
1.( )had not planned at all

C17. What method did you use for family planning?
1.( )none 2.( )pill 3.( )loop 4.( )rythem
5.( )condom 6.( )other

C18. Were you surprised at being pregnant? 1.( )no 2.( )yes

C19. If unplanned pregnancy, did you think of miscarriage?
2.( )yes 1.( )no

C20. If yes why did you decide to have baby?
1.( )life is precious 2.( )abortion is sin
3.(%' ^] * ((ove 4.( )should not abort it
5.( )age 6.( )husband 7.( )wanted

C21 Were you happy when you know that you are pregnant?
5.( )very happy 4.( )happy 3.( )half half
2.( )not happy 1.( )dislike

C22. How does your husband feel about your pregnancy?
6.( )very happy 5.( )somewhat happy 4.( )somewhat unhappy 3.( )very unhappy 2.( )he never said how he feels 1.( )he does't know
a. Have your marital relationship changed since pregnancy?
In what way?
b. Does your husband treat you differently?
c. Do you feel your husband differently?

C23. How do your parents-in-law feel about your pregnancy?
6.( ) Very happy 3.( ) Very unhappy
5.( ) Somewhat happy 2.( ) Never said their feelings
4.( ) Somewhat unhappy 1. She doesn't know
a. Do they treat you differently since pregnancy?
b. How do you feel about it?

C24. How do your parents feel about your pregnancy?
6.( )Very happy 3.( ) Very unhappy
5.( )Somewhat happy 2.( ) Never said how they feel
4.( )Somewhat unhapp 1.( ) She doesn't know

C25. Since you became pregnant, can you tell me which people, among those you live with, your family and friends, have been most helpful to you? Could you tell me their names, how they are related to you, and how they have helped you? Who was the most helpful one?
Name Relationship w/ mo. How do they help?
How often?

C25	C28	C31
C26	C29	C32
C27	C30	C33

Code for frequency 1. Often everyday 2. Once a day
3. 2,3 times /week 4. Once / week 5. Once / 2 week
6. Once in 3 weeks 7. Not at all
Code for help 1. Love and encouragement 2.Information and advice 3. Physical help 4.financial help

Code for relationship 1.husband 2.mother
3.mother-in-law 4.sister 5.friends 6.doctor

C34. From Whom and what was most helpful to your pregnancy?
from (C34.) what(C35.)

C36. From whom and what kind of help do you need more?
from (C36.) what(C37.)

CC1. From whom did you get information most about pregnancy and child care? 1.( )book or friends 2.( )sister or brother 3.( )doctor 4.( )mother-in-law 5.( )mother

CC2. How helpful were they? 1.( )very scanty 2.( )scanty 3.( )soso 4.( )enough 5.( )very much

C38. Have you had continuing ed. class? 2.( )yes 1.( )no

C39. If yes was it helpful in your pregnancy?
4.( )very helpful 3.( )helpful 2.( )so so 1.( )not at all

C40. Do you have experience of child care before pregnancy?
2.( )yes (siblings, nephew, niece, babysit) 1.( )no

THE CENTER FOR EPIDEMIOLOGICAL SCALES DEPRESSION SCALE

Now I'm going to read you a list of ways you might have felt in the past week. Please tell me how often you have felt that way in the past week.

During last week...	less than one	1-2	3-4	5-7
D1. I was bothered by things that don't usually bother me.	1	2	3	4
D2. I didn't feel like eating; My appetite was poor.	1	2	3	4
D3. I felt that I could not shake off the blues even with the help of my family and friends.	1	2	3	4
D4. I felt that I was just as good as other people.	1	2	3	4
D5. I had trouble keeping my mind on what I was doing.	1	2	3	4
D6. I felt depressed.	1	2	3	4
D7. I felt that everything I did was an effort.	1	2	3	4
D8. I felt hopeful about the future.	1	2	3	4
D9. I thought my life had been a failure.	1	2	3	4
D10. I felt fearful.	1	2	3	4
D11. My sleep was restless.	1	2	3	4
D12. I was happy.	1	2	3	4
D13. I talked less than usual.	1	2	3	4

D14.	I felt lonely.	1	2	3	4
D15.	People were unfriendly.	1	2	3	4
D16.	I enjoyed life.	1	2	3	4
D17.	I had crying spells.	1	2	3	4
D18.	I felt sad.	1	2	3	4
D19.	I felt that people disliked me.	1	2	3	4
D20.	I couldn't "get going".	1	2	3	4

D21. What would you say has been your greatest concern during pregnancy? Birth, baby, self, husband, work,
5.( )childbirth 4.( )baby 3.( )self
2.( )husband 1.( )work

D22. How did you deal with this concern or these fear?
1.( )devotion 2.( )listening music and reading books
3.( )family 4.( )job 5.( )professional help
6.( )self confidence 7.( )other

D23. Did you have any special religious devotions or practices during pregnancy? 2.( )yes 1.( )no

Traditional Customs

E1. Have you heard of fetal education? 2.( )yes 1.( )no

E2. From whom did you learn it?
1.( )Its familiar to me 2.( )parents 3.( )friends
4.( )sisters 5.( )doctors 6.( )books
0. ( )don't know

E3. Did you practice fetal education? 2.( )yes 1.( )no

E4. What did you do? 1.( )listening music & reading
2.( )refraining from bad behavior
3.( )refrain from some food 4.( )emotional calmness
5.( )picture of great man or beautful things

E5. Did it help you to cope with stress during pregnancy?
2.( )yes 1.( )no

E6. Do you think fetal education is important for child development? yes_____ no_____ (Prove into why).
5.( )Very important 4.( )somewhat important
3.( )mixed feeling 2.( )not important 1.( )not at all

E7. why? 1.( )fetal baby knows and feels what mother experience 2.( )mother's emotion has great impact on fetal development 3.( )I feel that it is important.
4.( )I don't know

E8. Did you dream for the pregnancy? 2.( )yes 1.( )no

E9. If yes, what did you dream? 1.( )animal 2.( )fish
3.( )flower 4.( )fruit 5.( )nuts etc. 6.( )stars ect.

E10. Did anybody else in the family dream for your pregnancy?
2.( )yes 1.( )no

E11. Who did dream? 1.( )mother 2.( )mother-in-law
3.( )sister 4.( )sister-in law 5.( )friend
6.( )neighbor 7.( )husband 8.( )other

E12. What was the dream? 1.( )animal 2.( )fish 3.( )flower
4.( )fruit 5.( )nuts etc. 6.( )stars ect.

E13. How do your feel about the dreams?
4.( )happy 3.( )not happy 2.( )don't care 1.( )bad
E14. How you feel during menstruation before pregnancy?
1.( )tired 2.( )headache 3.( )stomach upset
4.( )diarrhea 5.( )pains 6.( )tense
7.( )irritable 8.( )weak 9.( )bothered sleep
10.( )crying 11.( )lost appetite 12.( )depression
E15. At your first menstruation, how did you feel about it?
1.( )Proud 2.( )Pleased 3.( )Just accepted it
4.( )Unhappy 5.( )Frightened
6.( )Angry or rebellious, 7.( )Disgusted

Questions about your baby.
E16. Are you hoping for a boy or a girl?
1.( )Boy 2.( )Girl 3.( )either
E17. Why? 1.( )either 2.( )expectation of in-laws & husband
3.( )husband is eldest son 4.( )girls are agreeable
5.( )since only child---son preferrable
E18. What kind of baby would you like him/her to be?
1.( )healthy 2.( )good looking 3.( )eating and sleeping well 4.( )not crying much 5.( )bright
E19. What do you think good baby is?
1.( )eat and sleep well 2.( )agreeable
3.( )healthy andnot sick 4.( )other
E20. How many children do you think ideal to have?
1.( )one 2.( )two 3.( )three 4.( )four and more
E21. How many children do you like to have?
1.( )one 2.( )two 3.( )three 4.( )four and more
E22. Why? 1.( )not lonesome & good character development
2.( )financial burden of pregnancy and birth
3.( )two is optimum to manage 4.( )population policy
E23. What way do you think you will bring him/her up?
1.( )let him do what he likes to do
2.( )interfere and guide with firm principles
3.( )with loving and tender care
4.( )preventing over protection
5.( )don't know 6.( )other

Mothers have different ideas about when their babies should be able to do things, we would like to know how many months old you think your baby will be when he/she starts doing various things.
F1. At what age do you think your baby should first smile? ____mon.
F2. At what age do you think your baby should first crawl? ____ mon.
F3. At what age do you think your baby should first sit alone without support? ____ mon.
F4. At what age do you think your baby should be able to pull him/herself up by using furniture? _____ mon.
F5. At what age do you think your baby should be able to take his/her first steps without your help? _____ mon.

F6. At what age do you think your baby should be able to say his/her first real words, something more than mama? _____mon.

F7. At what age do you think your baby should be toilet-trained so he/she doesn't need to wear nappies? ____mon.

F8. At what age do you think your baby should begin to obey you when you say "no"? ____mon.

F9. What kind of quality of child would you prefer?

1.( )independence 2.obedience 3.( )honest
4.( )good 5.( )intelligence

F10. Finally, is there anything you would like to add? do you have remarks or suggestions?

_____
_____
_____

APPENDIX B

HOME POSTNATAL INTERVIEW QUESTIONNAIRE

G1. How do you feel to be a mother?
5.( )very happy 4.( )happy 3.( )so so
2.( )not pleased 1.( )very unhappy

G2. How do you feel toward yourself, husband, and in-laws?
1.( )matured woman 2.( )proud 3.( )so so 4.( )sorry
5.( )other

G3. toward your husband
1.( )trustworthy 2.( )intimacy 3.( )so so 4.( )sorry

G4. toward in-laws
1.( )real sense of belongingness to family
2.( )solution of discord 3.( )I did my responsibility
4.( )sorry 5.( )so so

G5. How do you feel about in-laws' attitude toward you?
1.( )very happy 2.( )happy 3.( )so so
4.( )not pleased 5.( )very unhappy

G6. Was it an easy delivery?
2.( )yes 1.( )no

G7. How did it go? 1.( )labor pain more than 8 hours
2.( )labor pain less than 8 hours 3.( )clear awareness
4.( )delivery of leading

G8. Whom did you imform first when your labor starts?
1.( )husband 2.( )parents 3.( )parents-in-law
4.( )sister 5.( )friends 6.( ) sister-in-law
7.( )other

G9. Was your husband with you during labor?
2.( )yes 1.( )no

G10. What other members of family were with/near you during labor and delivery?
1.( )mother 2.( )mother in law 3.( )sister & brother 4.( )sister in law 5.( )friend

G12. With whom did you feel most comfortable?
1.( )husband 2.( )mother 3.( )mother-in-law
4.( )sister(in-law) 5.( )friend 6.( )etc.

G13. problems in breast feeding that compel you for bottle feeding? 1.( )pain 2.( )nipple shape 3.( )little milk
4.( )sucking problem 5.( )etc.

G14. If breast feeding, how long?
1.( )less than 1 month. 2.( )2-6month 3.( )7-8months
4.( )10-12 months 5.( )more months 6.( )don't know

G15. What kind of traditional custom did you observe for the birth of the newborn? How do you value it?
3.( )kumjul (prevention line from guests)
2.( )prayer for easy delivery to three god mothers
1.( )samchil (three week celebration)

G16. Did you name baby? 2.( )yes 1.( )no
What is it?

G17. Who did name your baby?
1.( ) grandparent 2.( )parent of baby 3.( )relative

G18. What do you think about naming your baby by grandparents?
4.( )blessings from family 3.( )accept as custom
2.( )obeing with reluctance 1.( )oppose the custom
G19. What kind of name do you like to have?
1.( )Chinese writing 2.( )Hangul 3.( )both
G20. Did you or your baby receive any gift?
1.( )no 2.( )yes
G21. What kind gift did you and your baby have?
1.( )unbroken seaweed from ( )
2.( )baby blanket from (
3.( )baby goods from ( )
4.books from ( )
5.flowers from ( )
1.mother 2.mother in law 3.husband 4.friend
G23. Do you feel you are ready to take care of baby by yourself? 2.( )yes 1.( )no
G24. How do you think man's involvement in child care?
1.( )agree 2.( )must 3.( )for the sake of baby development 4.( )so so
G25. Do you want your husband's help? 1.( )no 2.( )yes
G26. Does your husband help you baby care? 1.( )no 2.( )yes
G27. What does your husband help you baby care?
5.( )feeding 4.( )bathing 3.( )diaper change
2.( )cooking or laudry 1.( )hospital visit
G28.
G29.
G30.
G31.
G32. Do you like to share the burden?
3.( )yes 2.( )no 1.( )common
G33. Where do you keep your baby?
Same room, separate room, crib or same mattress, separate baby mattress beside you.
2.( )same room 1.( )separate room
G36. How does he sleep?
2.( )care to sleep 1.( )let him sleep alone
G37. Do you sing traditional sleep-song?
2.( )yes 1.( )no
G38. How do you lay him for sleep?
2.( )spine 1.( )prone 0.( )side
G39. For outing, would you carry your baby on your back?
1.( )yes 2.( )no
G40. Would you do any other way?
1.( )holding 2.( )carrying of front 3.( )baby carriage
4.( )etc.
G41. why? 1.( )handy 2.( )face to face 3.( )close relationship 4.( )growth of baby
5.( )unsophisticated 6.( )other
G42. When baby cries during the night, who does take care of him? 1.( )herself 2.( )husband 3.( )both
4.( )mother/in law 5.( )nurse or caregiver

G43. Does your husband use other room since delivery?
1.( )yes 2.( )no
G44. If yes why? 1.( )confinement 2.( )concern for his job
3.( )nurse of mother 4.( )nurse of mother-in-law
G45. When you are sick, who would take care of your baby?
1.( )herself 2.( )husband 3.( )grandmother
4.( )mother in law 5.( )other
G46. If your husband take care of the baby, what could be the inconvenient?
1.( )It will effect on his work.
2.( )Unskilled care so baby uncomfortable. 3.( )etc.
4.( )nothing
G47. What do you need most?
1.( )Sleep and rest 2.( )helper for housekeeping and childcare 3.( )knowledge of baby care 4.( )nothing
5.( )to be with husband 6.( )feeding
G48. When you have disagreement, what does happen?
1.( )consult with professionals 2.( ) consult with experienced people 3.( )discuss up to agreement
4.( )mother 5.( )mother in law 6.( )etc.
G49. Who makes the final decision?
1.( )both parents 2.( )mother 3.( )father
4.( )grandparents (older person)
G50. How would you describe your baby?
1.( ) pretty 2.( )resembled father 3.( )lovely
4.( )angel 5.( )prince/princess 6.( )gift from God
7.( )etc.

SEX 1.( )male 2.( )female
FEEDING TYPE 1.( )BREAST 2.( )BOTTLE 3.( )COMBINED

APPENDIX C

THE POSTNATAL RESEARCH INVENTORY

Maternal Adaptation
Tell me how strongly you agree.

4. Strongly agree
3. Mildly agree
2. Mildly disagree
1. Disagree

H1.	The experience of having a baby has made me a happier person.	4	3	2	1
H2.	I am afraid I'll lose my temper with the baby.	4	3	2	1
H3.	I miss my freedom since having a baby.	4	3	2	1
H4.	I think that taking care of a baby is the most satisfying job a woman can do.	4	3	2	1
H5.	I think that a young baby should be handled only as much as is necessary to care for him.	4	3	2	1
H6.	Whenever the baby has a bowel movement I change the diaper.	4	3	2	1
H7.	Holding the baby is very soothing and relaxing.	4	3	2	1
H8.	Taking care of the baby leaves me on edge and tense.	4	3	2	1
H9.	Taking care of a young baby keeps me from doing many things I would like to do.	4	3	2	1
H10.	I haven't had time to rest or relax since I came home.	4	3	2	1
H11.	I enjoy feeding my baby.	4	3	2	1
H12.	There's no use in talking to a baby until he gets a little older.	4	3	2	1
H13.	When my baby wets his diaper I change him.	4	3	2	1
H14.	Caring for a baby makes me feel peaceful and contented.	4	3	2	1
H15.	A baby's crying gets on your nerves after a while.	4	3	2	1

H16.	We can't manage to go out since having the baby.	4	3	2	1
H17.	I enjoy cuddling my baby.	4	3	2	1
H18.	The best way to bring up a baby is to put him on a regular feeding schedule from the beginning.	4	3	2	1
H19.	There is not much you can do about a fussy baby, so there's no use worrying about it.	4	3	2	1
H20.	Since having a baby, I've been happy and cheerful.	4	3	2	1
H21.	Cleaning, diapering and caring for a baby can get a woman down.	4	3	2	1
H22.	Besides feeding and caring for my baby, I hold, talk, and play with him each day.	4	3	2	1
H23.	A very young baby is not social enough to be fun.	4	3	2	1
H24.	When the baby cries at night, I get up to see what might be causing it.	4	3	2	1
H25.	A baby gets spoiled if you pick him up when he cries.	4	3	2	1
H26.	I feel the mother should always be close enough to her baby to hear him if he cries.	4	3	2	1

Social Support

H27.	During the first six weeks at home I would have liked my mother or some older woman to help me take care of my baby.	4	3	2	1
H28.	The doctors and nurses at the hospital were friendly and interested in me.	4	3	2	1
H29.	At night my husband and I talk about what happened to the baby and myself during the day.	4	3	2	1
H30.	The baby takes so much time I haven't been able to do my work without help.	4	3	2	1
H31.	My husband has been very attentive and considerate since I had the baby.	4	3	2	1
H32.	I've wanted to talk about my experiences in caring for the baby.	4	3	2	1

H33. I've needed my husband's help in feeding, changing, bathing and caring for the baby. 4 3 2 1

H34. My friends and neighbor have been very thoughtful & helpful since I've had baby. 4 3 2 1

H35. In talking about your labor and delivery with your husband, you tell him, everything, a lot, just a few details, or very little. 4 3 2 1

H36. I've needed help after the first two weeks in caring for the baby and my household work.
1.( )everything 2.( )a lot
3.( )just a few details 4.( )very little

Post-natal Depression

H37. I have felt unhappy and in low spirits since having the baby.
4.( )often 3.( )sometimes 2.( )rarely 1.( )never

H38. Since having the baby, I've had crying spells.
4.( )often 3.( )sometimes 2.( )rarely 1.( )never

H39. I've been discouraged about not being able to care for the baby. 4.( )often 3.( )sometimes
2.( )rarely 1.( )never

H40. I had the "baby blues" (was depressed and discouraged).
4.( )For more than a week 3.( )For several days
2.( )For less than a day 1.( ) Not at all

APPENDIX D

MATERNAL SELF-REPORT INVENTORY (SHORT FORM)

Please note accurately the following statements describe how you feel. Read each item carefully and when you are sure you undertand it, indicate our answer by drawing a circle around the answer which best expressed the degree to which the statement is true for you.

CF Completely False
MF Mainly False
UN Uncertain or Neither True or False
MT Mainly True
CT Completely True

For example, circle CF is you feel that statement is completely false, circle MF if the statement is mainly false, circle MT is the statement is mainly true, and circle CT if the statement is completely true. If you are uncertain or feel that the statement is neither true nor false, then circle UN.

Please answer each item as honestly as you can and work rapidly as first impressions are as good as any. Try to answer every question, and if in doubt, circle the answer which comes closest to expressing your feelings. Although some of the statements seem to be similar, they are not identical, and should be rated separately. All of your answers will be treated with confidentiality. There are no right or wrong answers, so please answer according to your own feelings. If you have any questions or comments to make, please feel free to note them at the end of the questionnaire. Your comments are very much appreciated.

Thank you very much.

CF Completely False
MF Mainly False
UN Uncertain or Neither True or False
MT Mainly True
CT Completely True

I1.	I found the experience of labor and delivery to be one of the most un-pleasant experiences I've ever had.	CF	MF	UN	MT	CT
I2.	I think that I will be a good mother.	CF	MF	UN	MT	CT
I3.	I amd confident that I will have a close and warm relationship with my baby.	CF	MF	UN	MT	CT

I4. I don't have much confidence in my ability to help my baby learn new things. CF MF UN MT CT

I5. Looking forward to having a baby gave me more pleasure than accually having one. CF MF UN MT CT

I6. I have real doubts about whether my baby will develop normally. CF MF UN MT CT

I7. I found the delivery experience to be very frightening and unpleasant. CF MF UN MT CT

I8. I often worry that I may be forgetful and cause something bad to happen to my baby. CF MF UN MT CT

I9. I am confident that I will be able to work out any normal problems I might have my baby. CF MF UN MT CT

I10. I am concerned that I will have trouble figuring out what my baby needs. CF MF UN MT CT

I11. I worry about whether my baby will like me. CF MF UN MT CT

I12. I expect that I won't mind staying at home to care for my baby. CF MF UN MT CT

I13. I found the delivery experience to be very exciting. CF MF UN MT CT

I14. I and concerned about whether my baby will develop normally. CF MF UN MT CT

I15. I doubt that my baby could love me the way I am. CF MF UN MT CT

I16. It really makes me feel depressed to thing about all there is to do as a mother. CF MF UN MT CT

I17. I worry that I will not know what to do if my baby gets sick. CF MF UN MT CT

I18. It is difficult for me to know what my baby wants. CF MF UN MT CT

I19. I found the whole experience of labor and delivery to be one of the best experiences of my life. CF MF UN MT CT

I20. I am afraid I will be awkward and clumsy when handling my baby. CF MF UN MT CT

I21. I feel confident about being able to teach my baby new things. CF MF UN MT CT

I22. I am confident my baby will be strong and healthy. CF MF UN MT CT

I23. I feel that I will do a good job taking care of my baby. CF MF UN MT CT

I24. I know enough to be able to teach my baby many things which he/she will have to learn. CF MF UN MT CT

I25. I worry about being able to fulfill my baby's emotional needs. CF MF UN MT CT

I26. I am confident that my baby will love me very much. CF MF UN MT CT

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